PLEASE BRING COMPLETED
PAPERWORK TO YOUR APPOINTMENT
-DO NOT FAX OR MAIL BACK TO OFFICE

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS
Bariatric & General Surgery
Phone: 214-775-1356 Fax: 214-613-2231

Patient Responsibilities

To Our Patients:

Our office staff verifies your insurance benefits prior to the initial visit to our office to insure benefits are available for treatment of morbid obesity. We also obtain the co-pay amount for a specialist visit, deductible information as well as the co-insurance percentage. The insurance company and employer set these amounts and they are deducted from any payments made to Dr. Kennedy for services rendered and we are required to collect those amounts from our patients.

For our new patients we will collect the office visit co-pay at the time of the visit based on the information we received from the insurance company.

For our established patients we will collect the office visit co-pay if applicable, as well as any outstanding balances due from previous procedures and/or surgery. Any payment collected prior to surgery or procedure by the office staff has been applied to the account balance. Any balance on the account is based on the explanation of benefits provided to us by insurance company. Any questions regarding a balance should be directed to the insurance company for explanation.

**Please be aware we require 24 hours notice if you are unable to attend your appointment. Please notify us by phone to avoid a $25.00 "No Show" fee. You can cancel your appointment with anyone that answers the phone or if after hours, you may leave a message and let us know if you need a call back to reschedule.*

**As a courtesy to all of our patients, please also be aware your appointment will be re-scheduled if you are a minimum of 15 minutes late.*

Our goal is to provide the best possible care for our patients and make the journey to a healthier life as smooth as possible.

Thank you,

Dr. Kennedy

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS

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Phone: 214-775-1356 Fax: 214-613-2231

PATIENT REGISTRATION FORM

PLEASE FILL OUT ALL SECTIONS OF THIS FORM COMPLETELY TODAY'S DATE:_____

NAME LAST: _____FIRST:_____MIDDLE INITIAL: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____DRIVER LICENSE #:_____

HOME PHONE: _____CELL:_____WORK:_____

DATE OF BIRTH: ____/_____/_____GENDER: M F RACE: _____ SS#_____

MARITAL STATUS: _____SPOUSE/SIGNIFICANT OTHER NAME: _____DATE OF BIRTH:_____

E-MAIL (OPTIONAL)_____
(NOTE: By filling in your email you are hereby giving Kennedy Bariatrics staff permission to communicate with you via this email)

EMPLOYER INFORMATION

PLEASE CIRCLE ONE: FULL TIME PART TIME SELF EMPLOYEED HOMEMAKER STUDENT RETIRED DISABLED UNEMPLOYEED

EMPLOYER:_____OCCUPATION:_____

EMPLOYER ADDRESS:_____

WORK PHONE:_____WORK E-MAIL:_____

GUARANTOR INFORMATION

- LIST THE PERSON, OR INSURED NAME, RESPONSIBLE FOR THE BILL. USE FULL LEGAL NAME; NO NICKNAMES, PLEASE

RELATIONSHIP OF GUARANTOR TO PATIENT: SELF____ SPOUSE____ PARENT____ OTHER_____

NAME LAST: _____FIRST:_____MIDDLE INITIAL: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____DRIVER LICENSE #:_____

HOME PHONE: _____CELL:_____WORK:_____

DATE OF BIRTH: _____/_____/_____GENDER: M F SS#_____

MARITAL STATUS: _____SPOUSE/SIGNIFICANT OTHER NAME: _____DATE OF BIRTH:_____

E-MAIL:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP:_____

PHONE:_____ DOES EMERGENCY CONTACT SHARE ADDRESS? YES NO

EMERGENCY CONTACT MAY RECEIVE INFORMATION ABOUT YOUR MEDICAL CONDITION.

REFERRING DOCTOR:_____ PHONE:_____

INSURANCE INFORMATION

- PLEASE FILL OUT AS COMPLETELY AND CORRECTLY AS POSSIBLE, (AS ANY INCOMPLETE INFORMATION COULD LEAD TO DELAY IN PROCESSING) LIST PERSON, OR INSURED NAME, RESPONSIBLE FOR BILL, AND USE FULL LEGAL NAME; NO NICKNAMES, (SOME OF THIS INFORMATION CAN BE FOUND ON THE BACK OF THE CARD).
-

PRIMARY INSURANCE INFORMATION

INSURED NAME:_____ DATE OF BIRTH:_____ SS#:_____

PRIMARY INSURANCE COMPANY:_____ PLAN TYPE:_____

INSURANCE ID NUMBER:_____ GROUP NUMBER:_____

CLAIMS ADDRESS:_____

PROVIDER PHONE NUMBER:_____

NAME OF POLICY HOLDER:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SS#:_____

SECONDARY INSURANCE INFORMATION

INSURED NAME:_____ DATE OF BIRTH:_____ SS#:_____

SECONDARY INSURANCE COMPANY:_____ PLAN TYPE:_____

INSURANCE ID NUMBER:_____ GROUP NUMBER:_____

CLAIMS ADDRESS:_____

PROVIDER PHONE NUMBER: _____

NAME OF POLICY HOLDER:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SS#:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

YOUR INSURANCE CAN REQUIRE UP TO FIVE YEARS OF HISTORY. PLEASE GIVE US THE NAME, PHONE AND FAX NUMBER OF ALL THOSE PROVIDERS THAT WILL HAVE THOSE RECORDS.

PRIMARY CARE DOCTOR:_____ PHONE:_____ FAX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

ADDITIONAL DOCTOR:_____ PHONE:_____ FAX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

ADDITIONAL DOCTOR:_____ PHONE:_____ FAX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

- PLEASE LET US KNOW WHERE YOU PREFER YOUR PERSCRIPTIONS TO BE FILLED AT.

PHARMACY NAME: _____ PHONE:_____

- *I AUTHORIZE RELEASE OF MY MEDICAL RECORDS FOR USE IN PURSUING BENEFITS AND TO OTHER PHYSICIAN OFFICES AS DEEMED NECESSARY IN THE COURSE OF MY TREATMENT.*

HEALTH AND MEDICAL HISTORY

(PLEASE FILL OUT QUESTIONS AS COMPLETELY AS POSSIBLE)

WHAT IS THE REASON FOR YOUR VISIT?_____

WHAT TYPE OF BARIATRIC SURGERY ARE YOU INTERESTED IN? PLEASE CIRCLE YOUR CHOICE:

LAPAROSCOPIC ADJUSTABLE GASTRIC BAND LAPAROSCOPIC GASTRIC SLEEVE LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS

LAP BAND REMOVAL REVISION FROM LAP BAND TO SLEEVE OR BYPASS REVISION OF BYPASS TO BYPASS

OTHER:_____

HEIGHT:_____ WEIGHT:_____ BODY MASS INDEX:_____

IF YOU HAVE HAD A PREVIOUS BARIATRIC SURGERY, WHO WAS YOUR SURGEON: _____

ADDRESS: _____ PHONE: _____ FAX: _____

DID YOU HAVE YOUR AFTERCARE APPOINTMENTS/BAND FILLS WITH THE SAME SURGEON?: YES NO

IF NO – WHERE?_____

HOW MANY YEARS HAVE YOU BEEN AT YOUR CURRENT WEIGHT? _____

AT WHAT AGE DID YOU BECOME OVERWEIGHT?_____ YEAR?_____

WHAT WAS YOUR LOWEST ADULT WEIGHT?_____YEAR?_____

WHAT WAS YOUR HIGHEST ADULT WEIGHT?_____YEAR?_____

FOR FEMALES ONLY: ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? YES NO ARE YOU CURRENTLY PREGNANT? YES NO

TYPE OF CONTRACEPTION: _____LAST MENSTRUAL CYCLE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY CONTINUED

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST ALL._____

_____

LIST ALL MEDICATION YOU ARE TAKING, INCLUDING VITAMIN & MINERAL SUPPLEMENTS:

NAME OF DRUG	STRENGTH	FREQUENCY TAKEN	HOW LONG ON THIS MEDICATION

SURGICAL HISTORY

HAVE YOU EVER HAD: GALLBLADER SURGERY SPLEEN SURGERY ESOPHAGUS SURGERY STOMACH SURGERY HERNIA REPAIR SURGERY CAESARIAN SECTION ABDOMINAL HYSTERECTOMY SURGERY? PLEASE LIST ALL SURGERIES BELOW:

PROCEDURE	DATE	NAME OF SURGEON	FACILITY/HOSPITAL

PLEASE LIST ALL OTHER MEDICAL CONDITIONS, ILLNESS, OR IMPORTANT INFORMATION NOT MENTIONED PREVIOUSLY:_____

_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, PLEASE EXPLAIN.

_____

_____

WHAT CONCERNS YOU MOST ABOUT YOUR HEALTH?

_____

_____

PATIENT NAME:_____ DATE OF BIRTH:_____

MEDICAL HISTORY CONTINUED – PLEASE CHECK ALL THAT APPLY

CONDITION	Y	N	YEAR	COMMENTS	CONDITIONS	Y	N	YEAR	COMMENTS
Abdominal wall hernia					Heart Murmur				
Angina					Hepatitis				
Anemia/Type?					Herniated Disk				
Anorexia					Hiatal Hernia				
Anxiety					Inguinal Hernia				
Asthma					HIV/AIDS				
Bulimia					Hypothyroidism				
Bipolar					High Blood Pressure				
Panic Disorder					Kidney Disease				
Blood transfusion/tattoo					Kidney Stones				
Chronic Obstructive Pulmonary Disease (COPD)					Migraines				
Cirrhosis					Multiple Sclerosis (MS)				
Colitis/Irritable Bowel/Crohns Disease					Neuropathy				
Congestive Heart Failure					Osteoarthritis				
Coronary Artery Disease					Obstructive Sleep Apnea				
Coronary Bypass Surgery					Use CPAP or BIPAP machine?				
Deep Venous Thrombosis (Blood Clots in Legs)					Osteoporosis				
Depression					Osteopenia				
Diabetes – Type 1					Arrhythmia (abnormal heartbeat)				
Diabetes – Type 2					Peptic Ulcer Disease/Bleeding Ulcers				
Gestational Diabetes					Peripheral Arterial Disease				
Pre-Diabetes					Pulmonary Embolism				
Elevated Cholesterol					Rheumatoid Arthritis				
Elevated Triglycerides					Seizure Disorder				
Emphysema					Systemic Lupus				
Esophagitis					Other Autoimmune Disorders				
Reflux Disease (Gerd)					Stress Urinary Incontinence				
Heart Attack (MI)					Leaking when cough or sneeze				
Heart Disease					Leaking with straining				

Medications you have taken for weight loss:

MEDICATION	DATES	DOSAGE	PHYSICIAN SUPERVISED	AMOUNT OF WEIGHT LOST
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux				
Xenical (Orlistat,Alli)				
Meridia (Sibutramine)				
Other				

All Diets you have tried:

PROGRAM	YEAR	DURATION	PHYSICIAN SUPERVISED	AMOUNT OF WEIGHT LOSS
JENNY CRAIG				
ATKINS				
WEIGHT WATCHERS				
NUTRISYSTEM				
SOUTH BEACH				
OTHER				

PATIENT NAME:_____ DATE OF BIRTH:_____

HAVE YOU EVER BEEN TREATED FOR ANY EATING DISORDER? YES____ NO____. IF YES, PLEASE EXPLAIN:_____

DO YOU SMOKE? YES_____ NO_____. IF YES, FOR HOW LONG? _____ HAVE YOU QUIT? YES____ NO____. YEAR QUIT_____
DO YOU USE ALCOHOL? YES____ NO____. HOW OFTEN? DAILY_____ WEEKLY_____ OCCASIONALLY_____ RARELY_____
HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE? YES____ NO____. IF YES, PLEASE EXPLAIN:_____

IS YOUR SPOUSE /PARTNER SUPPORTIVE OF WEIGHT LOSS SURGERY?_____
IS YOUR FAMILY SUPPORTIVE OF WEIGHT LOSS SURGERY?_____

FAMILY MEDICAL HISTORY

CONDITION	MOTHER YES	MOTHER NO	FATHER YES	FATHER NO	SISTER YES	SISTER NO	BROTHER YES	BROTHER NO	OTHER YES	OTHER NO	YEAR	NOTES
DIABETES												
HYPERTENSION												
HYCHOLESTEROL												
DEPRESSION												
OBSTRUCTIVE SLEEP APNEA												
CORONARY ARTERY DISEASE												
ASTHMA												
CANCER												
EARLY DEATH												
THYROID DISEASE												
KIDNEY DISEASE												
SEIZURES												
BIPOLAR												
STROKE												
OTHER: PLEASE EXPLAIN												

PATIENT AND PROGRAM AGREEMENT

1) I AM READY TO PURSUE SURGERY AS AN OPTION OF TREATMENT FOR MY OBESITY.
2) I AGREE TO FOLLOW THE PROGRAM AS PRESCRIBED AND ACTIVELY PARTICIPATE IN MY AFTERCARE WITH COLLEEN KENNEDY, M.D.
3) I AGREE THAT I AM PRIMARILY RESPONSIBLE FOR REQUESTING AND OBTAINING ALL MEDICAL RECORDS REQUIRED BY INSURANCE IN A TIMELY MANNER FOR MY INSURANCE APPROVAL AND WILL FOLLOW UP BY INFORMING DR. KENNEDY'S STAFF OF ANY CHANGES TO MY INSURANCE STATUS, OR UP-DATES OF INSURANCE POLICIES - SUCH AS CHANGES OF INSURANCE FROM ONE CARRIER TO ANOTHER; AND GET A COPY OF THE NEW CARD TO THEM TO UPDATE THEIR SYSTEM.
4) I REALIZE THAT I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE IF MY INSURANCE COMPANY FAILS TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.

NAME:_____ SIGNATURE:_____ DATE:_____
(Printed Name)

PATIENT NAME:_____ DATE OF BIRTH:_____

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO DR. COLLEEN KENNEDY, MD, OR THE PHYSICIAN INDIVIDUALLY FOR SERVICES RENDERED TO MY DEPENDENTS OR ME BY THE PHYSICIAN OR UNDER HER/HIS SUPERVISION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND WHETHER OR NOT THE SERVICES I AM TO RECEIVE ARE A COVERED BENEFIT. I UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR ANY CO-PAY OR BALANCE DUE TO DR COLLEEN KENNEDY, MD IS UNABLE TO COLLECT FROM MY INSURANCE CARRIER FOR WHATEVER REASON.

MEDICARE/MEDICAID/AARP/SECUREHORIZON INSURANCE BENEFITS:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THESE PROGRAMS IS CORRECT. I AUTHORIZE THE RELEASE OF ANY OF MY OR MY DEPENDENT'S RECORDS THAT THESE PROGRAMS MAY REQUEST. I HEREBY DIRECT THAT PAYMENT OF MY OR MY DEPENDENT'S AUTHORIZED BENEFITS BE MADE DIRECTLY TO DR. COLLEEN KENNEDY OR THE PHYSICIAN ON MY BEHALF.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I CERTIFY THAT I HAVE RECEIVED AND READ A COPY OF THE PATIENT INFORMATION PRIVACY POLICY. I HEREBY AUTHORIZE DR. COLLEEN KENNEDY, MD OR THE PHYSICIAN INDIVIDUALLY TO RELEASE ANY OF MY OR MY DEPENDENT'S MEDICAL OR INCIDENTAL NON-PUBLIC PERSONAL INFORMATION THAT MAY BE NECESSARY FOR MEDICAL EVALUATION, TREATMENT, CONSULTATION, OR THE PROCESSING OF INSURANCE BENEFITS.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I CERTIFY THAT I UNDERSTAND THE PRIVACY RISKS OF THE MAIL, PHONE CALLS, AND E-MAIL. I HEREBY AUTHORIZE DR. COLLEEN KENNEDY, MD OR A REPRESENTATIVE TO MAIL, CALL OR E-MAIL ME WITH COMMUNICATIONS REGARDING MY HEALTHCARE, INCLUDING BUT NOT LIMITED TO SUCH THINGS AS APPOINTMENT REMINDERS, REFERRAL ARRANGEMENTS, AND LABORATORY RESULTS. I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS AUTHORIZATION AT ANY TIME BY NOTIFYING DR. COLLEEN KENNEDY, MD OR THE STAFF TO THAT EFFECT IN WRITING.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I UNDERSTAND THAT I MAY RECEIVE A SEPARATE BILL IF MY MEDICAL CARE INCLUDES LAB, X-RAY, OR OTHER DIAGNOSTIC SERVICES. I FURTHER UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CO-PAY OR BALANCE DUE FOR THESE SERVICES IF THEY ARE NOT REIMBURSED BY MY INSURANCE FOR WHATEVER REASON.

CONSENT TO TREAT:

I HEREBY CONSENT TO EVALUATION, TESTING AND TREATMENT AS DIRECTED BY DR COLLEEN KENNEDY, MD OR HER/HIS DESIGNEE.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(IF DIFFERENT FROM PATIENT)

GUARANTOR NAME (PLEASE PRINT):_____

PATIENT NAME:_____ DATE OF BIRTH:_____

HIPPA CONSENT

I GIVE THIS PRACTICE MY CONCENT TO USE MY PROTECTED HEALTH INFORMATION TO CARRY OUT MY TREATMENT, TO OBTAIN PAYMENT FROM INSURANCE COMPANIES, AND FOR HEALTH CARE OPERATIONS LIKE QUALITY REVIEWS.

I MAY REVIEW THE PRACTICE'S NOTICE OF PRIVACY PROCEDURES (FOR A MORE COMPLETE DESCRITION OF USES AND DISCLOSURES) BEFORE SIGNING THIS CONSENT.

I UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE THEIR PRIVACY PRACTICES AND THAT I MAY OBTAIN ANY REVISED NOTICES BY REQUEST FROM THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST A RESTRICTION OF HOW MAY PROTECTED HEALTH INFORMATION IS USED. HOWEVER, I ALSO UNDERSTAND THAT THE PRACTICE IS NOT REQUIRED TO AGREE TO THE REQUEST. IF THE PRACTICE AGREES TO MY REQUESTED RESTRICTION, THEY MUST FOLLOW THE RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, BY MAKING A REQUEST IN WRITING, EXCEPT FOR INFORMATION ALREADY USED OR DISCLOSED.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

RELATIONSHIP TO PATIENT:_____

THIS PAGE MUST BE READ AND SIGNED BY PATIENT

AUTHORIZED
RELEASE OF PROTECTED MEDICAL INFORMATION

Kennedy Bariatrics
Colleen Kennedy, M.D.
4310 Gaston Ave.
Dallas, TX. 75246
Office:214-775-1356 Fax:214-613-2261

FROM THE:
MEDICAL OFFICE OF: _____
(This is the name of the physician that wil be sending records.)

OFFICE #: _____ **Fax #:** _____

Please provide a copy of the medical records listed below by means of facsimile or mail for the person listed below to Dr. Colleen Kennedy.

THE INFORMATION COVERED BY THIS AUTHORIZATION INCLUDES:

- ☐ *Most recent History and Physical by physician*
- ☐ *Most recent CBC, LIPID, CMP, LIPID & TSH*
- ☐ *Psychological Evaluation*
- ☐ *Dietician/Nutritionist - all visits regarding weight loss attempts*
- ☐ *Records regarding weight loss attempts including medications, behavior modification, with documented weight at each visit by PCP: _____ months*
- ☐ *Documented weight for the years shown below (chart note showing WEIGHT, HEIGHT, BMI) for* ***ONE (1) NOTE FOR EACH YEAR LISTED:*** _____ _____ _____ _____ _____
- ☐ *Letter of Medical Necessity from treating physician*
- ☐ *Documentation of co-morbid conditions and treatment*
- ☐ *Most recent EKG*
- ☐ *All previous medical records*
- ☐ *Bariatric surgery operative note*
- ☐ *Post bariatric surgery follow up visit notes docmenting weight loss*
- ☐ *Other:* _____

PLEASE COMPLETE THE INFORMATION BELOW IN FULL

Patient: _____ Date of Birth: _____

Address: _____

_____
City State Zip

_____ _____
Signature of Patient ***Signature of Patient Representative***

_____ _____
Name of Patient (Printed) ***Relationship of Representative to Patient***

Date _____ ***Date*** _____

You may revoke or terminate this authorization by submitting a written revocation to Dr. Colleen Kennedy. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS

We may communicate with you by email in regard to your private health information. Due to the risk that electronic messages can be misdirected or intercepted by unintended parties, Kennedy Bariatrics cannot and does not guarantee the confidentiality of messages sent over the Internet. In addition, messages sent to or received from work email accounts also may be monitored or viewed by your employer. We do not believe that we should communicate private health information with you via e-mail unless you agree to do so, after you have considered these risks. If you wish to communicate by email, please respond by signing your consent below.

If you wish to communicate by e-mail, please respond by signing your consent below.

_____

Patient Name Date

_____

Email Address

_____

Signature of Patient