WELLSTAR COMPREHENSIVE BARIATRIC SERVICES, LLC A CENTER OF EXCELLENCE IN BARIATRIC SURGERY
55 Whitcher Street, Suite 410, Marietta, GA 30060
PH 770-919-7050 FX 770-919-7051
Office E-mail: bariatricsurgery@wellstar.org

PLEASE READ CAREFULLY BEFORE SENDING IN YOUR PAPERWORK

Thank you for your interest in our Comprehensive Bariatric Program.

You must complete the attached questionnaire and insurance worksheet and return it to our office. You can e-mail, mail, or fax this paperwork back to us using the information listed above. Please **do not leave any blank spaces** – if the information does not apply to you, please mark it as such. *If the paperwork is incomplete, it will be returned to you for completion.*

The most common 'missed' information:

- Please be sure to put your name and DOB on top of all the pages that have requested it.
- Be sure to initial and date in the areas of the pages that have requested it.
- Be sure to read the ***Office Policies***, initial, sign and date.
- You **MUST** list *'something'* in the Diet History section of the questionnaire. *(This is crucial information that your insurance reviews to show that you have failed past dieting attempts, therefore determining medical necessity.*
- You must contact your insurance company to obtain your benefits information. You are **ONLY** calling to get your benefit information. We are not trying to do a *pre-certification / authorization* at this time. If your insurance has a **total exclusion** for weight loss surgery, then you will need to complete the 'self-pay portion' of the financial worksheet, as that means they **WILL NOT** cover the surgery.
- You ARE required to calculate the second page of the benefits and insurance worksheet. (Even if the amount is zero) This is to give you an 'estimate' of what you could possibly owe **PRIOR** to the surgery.

**Unfortunately, Ambetter, Oscar, Cigna HIE GA Connect, or any other Marketplace Insurance does not cover the bariatric surgery. From our previous attempts for approval from those Insurances, none of those cases were approved for the bariatric surgery. They will cover your initial consultation with the surgeon, but again, does not cover the bariatric surgery itself. Therefore, you would be considered self-pay.

SELF-PAY INFORMATION:

The initial visit is $340.80. We do ask for a $500.00 deposit that will go toward the cost of your surgery. The cost of the surgery would depend on what surgery you and the doctor decided on. The cost of the surgery is due in full prior to the surgery. **We do not have a payment plan available.** If you cancel your surgery within 2 weeks of the scheduled date, the 500.00 is NON-REFUNDABLE. If you cancel it outside of the 2 weeks, it is, of course, 100% refundable, as long as there are no outstanding balances within Wellstar.

Once your paperwork has been reviewed by the nurse and it is determined that you qualify for Bariatric Surgery, someone from our office will reach out to you to schedule an initial consultation.

Regards,

Wellstar Bariatric Surgery

WELLSTAR Medical Group

Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name		Date of Birth	Age	Patient Gender ☐ M ☐ F
Street Address	City	State	Zip Code	Social Security Number	
Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary	Email Address		
Need Interpreter? ☐ Yes ☐ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ☐ Yes ☐ No	Race	Religion
Activate MyChart ☐ Yes ☐ No	Employer Name		Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student		
Employer Address	City	State	Zip Code	Employer Telephone	
Emergency Contact Last Name	First Name		Pharmacy Telephone Number		
Emergency Contact Relation to Patient	Legal guardian? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Visually Impaired? ☐ Yes ☐ No	Home Telephone ☐ check if primary	Work Telephone ☐ check if primary	Cell Telephone ☐ check if primary
Primary Care Physician						

2. Responsible Party / Guarantor ☐ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code
Guarantor Relation to Patient	Guarantor Gender ☐ M ☐ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student		Employer Telephone		

3. Medical Insurance Policy Holder ☐ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

WMG Patient Registration Form - page 2

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WellStar Medical Group to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Consent to Contact

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Signature of Patient / Legal Guardian:	Date:

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Wellstar

Wellstar Comprehensive Bariatric Services

Medical History Questionnaire

Today's Date: _____/_____/_____

Name: _____ Age: _____ Date of Birth: _____/_____/_____
Gender: Male ____ Female ____
Height (inches): _____
Weight (pounds): _____

***Are you most interested in surgery for weight loss (i.e. bariatric surgery)?** Yes☐ No ☐Maybe ☐
***Which of the operations below appeals to you? (Please check all that apply)**
☐ BPD/ Duodenal Switch ☐ RNY Gastric Bypass ☐ Sleeve Gastrectomy ☐ Band Removal
☐ Unsure ☐ All ☐ Other _____
***Are you most interested in medical weight loss (i.e. non-surgical)** Yes ☐ No ☐ Maybe ☐

Race/Ethnicity:
____ Caucasian/White ____African American/Black ____Asian American ____Hispanic/Latino ____ Other

***Education Level Completed**:
☐ Grade School ☐High School ☐College ☐Post-Graduate ☐ Degree: _____
***How did you hear about our program?**
☐ Physician ☐ Internet (site _____) ☐ TV ☐ Radio ☐ Word of Mouth ☐ Magazine
***Relationship Status**☐ Single, Never Married☐ Married☐ Divorced☐ Separated☐ Widowed
***Employment Status:**
☐Full-Time ☐ Part-Time ☐Retired ☐Unemployed
***Disability Status:**
☐ N/A ☐ Short-Term ☐ Permanent

___ Yes ___ No Do you drink alcohol? How many _____ drinks/day or _____ drinks/week?
___ Yes ___ No Do you ever use alcohol heavily? When did you quit using alcohol? _____
___ Yes ___ No Have you attended AA? When? _____
___ Yes ___ No Have you ever used illicit drugs? What type(s)? _____
When did you quit using drugs? _____ How? _____
___ Yes ___ No Do you currently smoke cigarettes? How many packs/day? _____What age did you start? _____
___ Yes ___ No Do you currently Vape?
___ Yes ___ No Are you a former smoker? What age did you start? _____ Stop? _____ Packs/per day? _____

***Please list the names of any physicians you have seen in the past <u>two years</u>:**

	Provider Type	Provider Name		Provider Type	Provider Name
	Primary Care MD/DO			**Psychiatrist**	
	Pulmonologist			**Nephrologist**	
	Cardiologist			**Neurologist**	
	Psychologist			**Endocrinologist**	

***If referred by a doctor, please list the referring physician**: _____
***Does your Primary Care Physician (PCP) know you are considering Bariatric Surgery?**☐ Yes☐ No
***Is your PCP supportive of you seeking Bariatric Surgery?**☐ Yes ☐No * **May we contact your PCP**☐ Yes☐ No
***Has your Primary Care Physician worked with you to loose weight?** ☐Yes ☐ No
***May we contact your Psychologist or Psychiatrist?** ☐Yes ☐ No

PLEASE PRINT NAME: _____ **DATE OF BIRTH:** ____/____/____

Your Weight History

***Has your weight been gradual or rapid?** _____ Gradual _____Rapid

***When did you begin to gain weight?** ___ Childhood ___ Puberty ___ Pregnancy ___ Adulthood ___ Menopause

***Were you obese as a child?** _____ Yes _____ No ***What was your weight at age 18?** _____

***How many years have you been overweight?** _____ ***What was your weight 5 years ago?** _____

***What has been your highest weight?** _____ ***At what age?** _____

***How long have you been at your present weight?** _____

***Do you feel that your weight gain has been associated with any of the following life changes?**

____ College ____ Career Changes ____ Marriage ____ Divorce ____ Death of a loved one ____ Stress

***Do you have a history of binge eating?** _____ Yes _____ No ***What age did you first go on a diet?** _____

***What do you consider to be your 'problem' foods?** _____

***Do you consider yourself to be an over-eater?** _____ Yes _____ No

***When you aet with friends, do you eat more than they do at a meal?** _____ Yes _____ No

***Do you ever feel full?** ____ Yes ____ No ***Do you eat just before bed?** ____ Yes ____ No

***Do you wake up during the night and eat?** _____ Yes _____ No

***Do you snack between meals?** ____ Yes ____ No ***What kind of snacks?** _____

***Do you eat when you are not hungry?** ____ Yes ____ No ***How many times do you eat out per week?** _____

****Your Diet History:*** **THERE MUST BE SOMETHING LISTED UNDER DIET HISTORY. EVEN IF IT WAS A DIET THAT YOU TRIED ON YOUR OWN.** This information is usually required by your insurance company to determine medical necessity. Please fill it out as completely as possible and begin collecting any possible records of your **weight loss programs** from the past 3-5 years.

Name of Program	Pounds	When	Duration	MD Supervision? Name	Medications?	Why did it not work?
Behavior Modification						
Cabbage Soup Diet						
Blood Type Diet						
Dr. Atkins						
Exercise Program						
HMR						
Jenny Craig						
Low Carbohydrate						
Low Fat						
Medifast						
Metabolife						
Nutri-System						
Optifast						
Overeaters Anonymous						
Physicians' Weight Loss						
Quick Weight Loss Center						
Keto						
Scarsdale						
Slimfast						
South Beach Diet						
Sugar Busters						
Whole 30						
Mediterranean Diet						
Weight Watchers						
Paleo Diet						
Other						
Other						
Other						

PATIENT MEDICATION AND SUPPLEMENT LIST

Name: ______________________________ **Date of Birth:** ____________________

Pharmacy: ____

Medication Allergies: ____

PLEASE LIST ALL MEDICATIONS:

Medication Name	Dose	Taken By	Frequency (times per day)	Medication used for
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
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		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		
		☐ Mouth ☐ injection ☐ Inhaled ☐ ________		

Patient Signature: ______________________________ **Date:** ____________

Note: By entering your name here, you indicate that you have entered your medications to the best of your knowledge.

Your Surgical History: Have you had any previous Surgery? ☐ Yes ☐ No **If yes, please list:**

Type of Surgery	For what disease/condition?	Laparoscopic or open?	Year

Your Medical History: **PLEASE PRINT NAME:** _____

Have you ever had, or been diagnosed with (please answer EVERY question by circling yes or no) :

Yes No Cancer Age of diagnosis: _____ What part of your body? _____
Yes No Rheumatic/Scarlet Fever
Yes No Chronic Headaches
Yes No Glaucoma
Yes No High blood pressure Age you started medication(s) _____
Yes No Heart Disease Age of diagnosis: _____
Yes No High Triglycerides Age you started medication(s): _____
Yes No High Cholesterol Age you started medication(s): _____
Yes No Diabetes Age of diagnosis: _____
Yes No Thyroid Disease
Yes No Chest Pain or Tightness
Yes No Abnormal Heart Beats/Rhythms (including murmurs)
Yes No Heart Problems Please Describe: _____
Yes No Heart Attack When? _____
Yes No Easy Bleeding or Clotting Disorder Age of diagnosis: _____
Yes No Blood Clots Where/when: _____
Yes No Blood Clots in your lung Where/when: _____
Yes No Do you have a Vena Cava Filter? When: _____
Yes No Deep Vein Thrombosis What year: _____ Where in your body: _____
Yes No Easy Bruising
Yes No Leg swelling Which side? Or both? _____
Yes No Vascular disease Age of diagnosis: _____
Yes No Carotid disease Age of Diagnosis: _____
Yes No Sleep Apnea Have you had a sleep study? ☐ Yes ☐ NO
Yes No Use CPAP/BIPAP (circle one) What is your pressure setting? _____
Yes No Pneumonia When? _____
Yes No Emphysema/COPD
Yes No Lung Disease
Yes No Shortness of Breath
Yes No Bronchitis How many times? _____
Yes No Use home Oxygen
Yes No Asthma
Yes No Diagnosed Gastro-Esophageal Reflux (GERD)
Yes No Heartburn How often: _____ When does it occur: _____
Yes No Ulcers of the stomach When? _____
Yes No Endoscopy When? _____
Yes No Gallstones When? _____
Yes No Gallbladder Surgery When? _____
Yes No Jaundice
Yes No Arthritis What sites? _____
Yes No Osteoporosis What sites? _____
Yes No Degenerative Joint Disease What sites? _____
Yes No Chronic Joint Pain What sites? _____
Yes No Chronic Back Pain Levels: ☐ Upper ☐ Middle ☐ Lower ☐ Multiple
Yes No Numbness or Tingling Where? _____
Yes No Used Steroids in last 6 months What Type? ☐ Oral ☐ inhaler Why? _____
Yes No Blackouts? When? _____
Yes No Seizures? When? _____
Yes No TIA When? _____
Yes No Stroke When? _____
Yes No Anemia Are you being treated? Yes No What treatment? _____

PLEASE PRINT NAME: _____ **DATE OF BIRTH:** _____

Yes No Liver Disease
Yes No Pancreatitis When? _____
Yes No Hepatitis When? _____ What Type? _____
Yes No Frequent Diarrhea Please Explain: _____
Yes No Frequent Nausea or Vomiting
Yes No Inflammatory Bowel Disease (i.e. Crohn's Disease or Ulcerative Colitis)
Yes No IBS (irritable bowel syndrome)
Yes No Stool Leakage Please Explain: _____
Yes No Hernia Where in your body? _____
Yes No Urine loss w/cough, sneeze, etc.
Yes No Kidney Disease
Yes No Gout
Yes No Renal/Kidney Failure Do you undergo dialysis? ☐ Yes ☐ No
Yes No Kidney Stones What Type? _____
Yes No Irregular Periods Age of menses: _____ Average length of period: _____
Yes No Polycystic Ovarian Syndrome (PCOS)
Yes No Have you been pregnant? How many C-sections? _____
Yes No Hysterectomy Reason: _____
Yes No Problems with conceiving
Yes No Have you ever been in counseling or advised to seek counseling?
Yes No Have you experienced abuse in your life? If yes: ☐ Emotional ☐ Physical ☐ Sexual
Yes No Depression
Yes No Bi-Polar Disorder
Yes No Panic Attacks
Yes No Schizophrenia Age of diagnosis: _____
Yes No Do you have any other psychological problems not listed above? If yes, please describe: _____
_____
Yes No Any other medical problems we should know about? _____
_____
Yes No Are you disabled? If so, please describe: _____

Your Family History: Please check box if a sibling, parent, grandparent, aunt, or uncle has had any of these:

	Sibling	Father	Mother	Other		Sibling	Father	Mother	Other
High Blood Pressure					Thyroid Disease				
Diabetes					COPD/Emphysema				
High Cholesterol					Heart Disease/Heart Attack				
Depression					Heart Surgery				
Sleep Apnea					Stroke				
Obesity					Cancer (site_____)				

Is there any ***male*** or ***female*** in your family with a personal history of any of these?

Yes No History of any kind of heart disease in any member of your ***immediate family*** (father, mother, sister, brother) occurring when they were under the age of 60.

Yes No History of any kind of heart disease in anyone in your ***extended family*** (grandparents, aunts, uncles, cousins) occurring when they were under the age of 70.

Is there any other information you would like to tell us? _____

☐ By checking this box and entering my name below, I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Revised 10/28/24 DRT

SURGICAL BENEFIT AND INSURANCE WORKSHEET 2025

NOTE: YOU MUST SEND A COPY OF BOTH FRONT & BACK OF INSURANCE CARD WITH QUESTIONNAIRE!!!

Use this sheet to check your **WEIGHT LOSS SURGERY** benefits when calling benefits/customer service number on your insurance card.
LEAVE NO BLANKS- *if answer is "none" or $0 or N/A, enter that into the space* (you can make notes on this sheet).

PATIENT: _____ DOB: _____

INS. CO Name: _____ Member ID# _____

INS CO PHONE #: _____

***When you call the insurance company phone number, you will get an automated menu of options. Choose "Coverage & Benefits" to obtain your basic information.** You should then speak to a representative to get answers to the following questions:

Person you spoke with NAME: _____ Date/Time: _____ Call Reference# _____
Type of Plan (circle one): HMO POS PPO INDEMNITY EPO OTHER_____
Does your insurance require a **REFERRAL** from PCP/PCM/Primary Care Doctor to see a Specialist? ☐ YES ☐ NO

ALL QUESTIONS MUST BE ANSWERED

Does your plan have a **WEIGHT LOSS SURGERY "EXCLUSION"**? ☐ YES ☐ NO ****IF YES, PLEASE STOP AS YOUR INSURANCE WILL NOT COVER BARIATRIC SURGERY****

Does the Plan have "WEIGHT LOSS SURGERY BENEFITS"? ☐ YES or ☐ NO
Which WEIGHT LOSS SURGERY CODES below are covered/reviewed under this plan? (CIRCLE CODES covered):

43644	43775	43845
Lap RNY	Gastric Sleeve	Duodenal Switch

OUT-OF-NETWORK BENEFITS? ☐ YES or ☐ NO

DO YOU REQUIRE A SUPERVISED OR STRUCTURED WEIGHT LOSS or DIET PLAN? ☐ YES or ☐ NO
*IF **YES**,* HOW MANY MONTHS or SESSIONS: ☐ 3 MONTHS ☐ 6 MONTHS ☐ 12 MONTHS 12 SESSIONS
Is this *CONSECUTIVE* MONTHS ☐ YES or ☐ NO

NEED **HISTORY of MORBID OBESITY Documentation**? (Check box for # of years) ☐ 2 Year ☐ 3 Year ☐ 5 Year

*DO YOU ***REQUIRE*** AN ***INSURANCE SPECIFIC*** CENTER OF EXCELLENCE such as Aetna I.O.Q./Institute of Quality, BCBS Blue Distinct Facility, *CIGNA* COE or UHC "*OPTUM* COE" ☐ YES or ☐ NO

OR CAN YOU USE *ANY* ASMBS CENTER OF EXCELLENCE IN BARIATRIC SURGERY? ☐ YES or ☐ NO
TWO ABOVE ANSWERS CANNOT be BOTH "YES" or BOTH "NO" Please ascertain which is YES and which is NO
Is WELLSTAR KENNSTONE HOSPITAL *In-Network* *ALLOWED BARIATRIC Surgery Facility* (give Tax ID & NPI below: TAX ID# 5820 32904; NPI# 164 924 8626) YES ☐ or NO ☐

Effective date of Policy: _____ **Specialist Co-Pay** $_____ **Hospital CO-PAY $**_____/DAY

	In-Network	Out-of-Network
Deductible:	$_____	$_____
Deductible already met this year:	$_____	$_____
Deductible REMAINING (*patient's* responsibility to pre-pay for surgery)	$_____	$_____
	In-Network	**Out –of-Network**
Out-of-pocket (OOP) expense (patient responsibility before 100% covered)	$_____	$_____
Out-of-pocket (OOP) expense already met this year:	$_____	$_____
Out-of-pocket (OOP) REMAINING (*patient's* responsibility to pre-pay for surgery)	$_____	$_____

Initial_____ Date _____

See SURGERY FEE CALCULATOR (NEXT PAGE) to determine ESTIMATED AMOUNTS DUE PRIOR TO SURGERY

SURGERY FEE CALCULATOR (*Estimate Only, Prices Subject to Change*) Leave NO BLANKS

PROVIDER	ESTIMATED AMOUNT DUE PRIOR to SURGERY *Choose which column applies:* INSURANCE or SELF-PAY	INSURANCE PATIENT Circle Surg Type	SELF PAY Circle Surgical Type Below
OFFICE VISIT	***self-pay price could vary between $500-$600 for the initial Visit depending on how the provider has coded the visit.*** INSURANCE patient: Amount will be your deductible OR Co-pay	$ _____	**$500-$600 + $500 surgery deposit
SURGEON FEE	*INSURANCE patient* amount is your remaining deductible. If your amount is zero, please mark it as "0"	$ _____	$4,532 DS $3,997.60 RNY $2,727.20 SLV $2,031 BAND Removal
SURGICAL ASST FEE	Both INSURANCE & SELF-PAY Patients	Patient amount is determined after Insurance is billed	TBD $800-$3,000
Anesthesia Fee	INSURANCE PATIENTS- anesthesia will be billed to your insurance post-surgery. Patient amount TBD after insurance.	BILLED to insurance after Surgery if Insurance Patient	BILLED after Surgery. Amount TBD
HOSPITAL FEE	NOTE-INSURANCE PATIENTS: This amount is usually, *at minimum,* your REMAINING OOP (Out of Pocket) amount for most insurance plans. NOTE- some insurance plans have a Co-Pay Amount/per day for HOSPITAL STAY	$_____	$19,000 DS $14,500 RNY $8,500 SLV
TOTAL EST. COST DUE *PRIOR to SURGERY*	Add each item in each row for the column that is specific to your *surgery type* and *payment category* (Insurance or Self-Pay) for the TOTAL DUE ALL REMAINING Deductibles & OOP ARE ALL DUE BEFORE SURGERY- NO PAYMENT PLANS	$_____	$_____
PAYMENT METHOD	DEBIT/CREDIT/Visa/MC/Discover/Amx/CASH/ *Cashier's* Check/Money Order (no personal checks)		
SELF-PAY NOTE	If *ADDITIONAL PROCEDURES* are performed at the time of bariatric surgery: Cholecystectomy (Gallbladder Removal), Lysis of Adhesions, Hiatal Hernia Repair, Appendectomy, Liver Biopsy... Or add'l consults from other providers in the hospital, there *WILL BE ADDL FEES* collected postoperatively by the HOSPITAL.		

YOU MUST CONTACT THE NUMBERS BELOW FOR *YOUR PORTIONS* DUE *PRIOR* TO SURGERY

*WellStar Kennestone Hospital – (call *ONLY AFTER* surgery scheduled) 470-610-0547(Patient Access Services)
NOTE-CFA/Community Financial Asst. Program through WellStar does NOT cover Bariatric Surgery Hospital Fees
ALL PAYMENTS ARE DUE PRIOR TO SURGERY. Wellstar DOES NOT offer payments plans for Bariatric Surgery.
NOTE:Any remaining unmet Deductibles, Co-Pays, and/or Out of Pocket (OOP) amounts for HOSPITAL are collected UPFRONT PRIOR TO SURGERY, not arranged as a bill-pay after surgery.

Bariatric surgery DOES NOT qualify for payment arrangements with the hospital. Initial _____ Date _____

Please initial that you fully understand the financial responsibility for bariatric surgery. Initial_____ Date _____

WELLSTAR COMPREHENSIVE BARIATRIC SERVICES, LLC
A Certified "Center of Excellence" in Bariatric Surgery
Dr. Fritz Jean-Pierre, Jr., M, FACS
Katrice Harris, ANP-BC
55 Whitcher Street, Suite 410
Marietta, GA 30060
PH: 770-919-7050 **FX: 770-919-7051**

RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Last Name First Name Middle Name Birth Date (Month/day/year)

Street Address City State Zip Code

Home Phone # Cell Phone #

Release Information TO:
WellStar Comprehensive Bariatric Services PHONE: 770-919-7050 Please FAX: 770-919-7051
Address: 55 Whitcher Street, Suite 410 Marietta, GA 30060

Release Records FROM:

I hereby authorize **(doctor/hospital):** _____
ADDRESS: _____
PHONE: _____ **FAX:** _____
to release any medical information as indicated below to the person or organization stated above:

☐ **Progress Notes to show any MD Monitored or Structure Diet & Exercise Plans**

☐ Information related to mental or nervous disorders; Pathology Reports, Clearance Letters, Operative Notes

☐ X-Rays/Radiology tests/reports, AND/OR Hcg Diet and B-12 injection records

☐ **Physician/MD H/O Patient Weights/MOB for past 5 years:**

(e.g., Progress/Office Notes with 1 obese weight per calendar year:2017, 2018, 2019,2020, 2021,2022,2023,2024)

Purpose of disclosure: ☐ Patient Request ☐ Employer ☐ Referral/Second Opinion ☐ Insurance ☐ Other

I understand that protected health information (PHI) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I have a right to revoke this authorization at any time and that my revocation must be submitted in writing to WellStar Comprehensive Bariatric Services. I understand that my revocation cannot be retroactive and is not effective to the extent that the persons or organizations which I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. I understand WellStar Comprehensive Bariatric Services assumes no responsibility for the use or misuse by others of my PHI disclosed under this authorization. I hereby release WellStar Comprehensive Bariatric Services from all legal liability that may arise from this authorization.

Patient Signature (or Signature of Authorized Representative) * Relationship to patient Date of Authorization

Print Name Expiration Date of Authorization

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Fritz Jean-Pierre, Jr., MD Katrice Harris, ANP-BC
55 Whitcher Street, Suite 410, Marietta, GA 30060
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OFFICE POLICIES

Initial ____ ***FEES**

1. ALL COPAYS OR SELF-PAYMENTS ARE DUE BEFORE YOU ARE SEEN
2. If you are self-pay for surgery, we collect a $500.00 deposit at your initial visit. The remainder of what you owe for the surgeon fee must be paid prior to surgery.
3. Payment plans are NOT available for bariatric surgery.
4. For your convenience, we accept cash, checks, Visa, Discover, American Express and MasterCard

Initial ____ ***MEDICAL FORMS**

Filling out disability forms, FMLA forms, treating physician statements, and other supplemental insurance forms require a fee of $25.00 for each form. The fee must be paid in advance prior to completion. If a form must be filled out multiple times, this fee will apply each time. Please note: There may be a turnaround time of up to 14 days for completion.

Initial ____ **APPOINTMENTS**

Patients are seen by appointment only.

Initial ____ **MEDICATION REFILLS**

Medication refill requests are handled as follows:

1. If it is a medication that our providers have prescribed before or after a visit with the bariatrician, there will be authorized refills up to 6 months after your initial prescription, depending on the provider's determination. Additional lab work and/or office visits may be required in some cases.
2. Our doctors **will NOT** refill any medications prescribed by another doctor.

Initial ____ **INSURANCE**

Our doctors are contracted with most major insurance plans. Patients are responsible for payments as indicated by their insurance contract.

Initial ____ **REFERRAL**

If your insurance plan requires a referral for you to be seen by a specialist, it is ***your responsibility to ensure that your primary care physician orders from EPIC or gives you a referral before you are seen.***

Initial ____ **EMERGENCIES**

Our surgeon or a covering physician will be on call and available for emergencies at all times. If your situation is life-threatening, call 911. If your situation is not life-threatening, please call our office during regular business hours (Monday through Friday, 8:00 a.m. to 5 p.m.) and pass your information on to staff. After hours and on weekends, please call our main number to reach the answering service. They will notify the doctor on call of your emergency. Appointments, medication refills, and non-emergency calls will be handled during regular business hours.

Initial ____ **LATE /CANCELLATIONS**

If you are more than 15 minutes late for an appointment, you may be asked to reschedule or wait until the end of the session or the day before you are seen. The doctor reserves the right to have you reschedule for another day.

Any appointment cancellation within 48 hours of the appointment will be considered a late cancellation. If we do not receive a call cancelling an appointment, it will be considered a 'no show'. Any combination of 3 documented no-shows or late cancellations in a 12-month period can lead to dismissal from the practice. This policy is in place to ensure the integrity of our schedules so that we can schedule other patients in a timely manner.

Initial ____ **INTERNET AND CHAT ROOM**

Many of our patients like to go online to communicate with other bariatric patients, as well as to search for information. While we encourage communication with other patients who are experiencing or have experienced the same issues as you, it is important to understand that while online in any chat room or similar forum, the information you provide may be viewed by others and is not private. These forums are public and may not be regulated. You will not be able to control the information as to third parties, Your access to or use of your personal information. Also, the information obtained in the chat room or similar forum may not be medically sound. Even though it may have worked for someone else, the suggestion may not work for you at all, or worse, be harmful to you.

Please sign and date indicating that you have read and understood the policies.

_____ _____

Signature Date

Revised 3/12/25 DRT

Wellstar
HEALTH SYSTEM

Authorization and Consent to Photograph
and Publish Information, Statements and Images

The undersigned hereby authorizes and consents to permit Wellstar Health System, Inc. and its affiliates, and its and their respective successors and assigns (collectively, "Wellstar") to use and publish, or permit other persons to use and publish, in any public manner Wellstar deems reasonably appropriate, his or her name, voice, photograph, likeness, quotes, stories and/or any other information, statements or images (collectively, "Personal Materials") obtained in connection with the undersigned's employment by, or other performance of services for, Wellstar:

(1) for any commercial or non-commercial purposes, including but not limited to, for marketing, advertising, fundraising, development, public relations, media relations, charitable, educational and scientific purposes; and

(2) in the form of print, audio, visual, social media and other online channels, including but not limited to, articles, blogs, web sites, brochures, pamphlets, newsletters, fliers, posters, advertisements, newspapers, film, live or taped television transmission, videotape, radio broadcast and internet publication, or any other medium now known or hereafter developed

it being understood and agreed that such authorization is subject only to the following limitations, if any: _____

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The term "photograph" as used in this agreement shall mean motion picture, still photography or visual recording of any kind and in any format such as digital files, slides, negatives, prints, videotape, video disc, and any other means of recording and reproducing images, including composite or modified representations.

Except as specifically stated above, the undersigned hereby waives any and all rights he or she may have with respect to any Personal Materials and all images or materials created from them. Without limiting the generality of the foregoing, the undersigned specifically waives (i) any rights he or she may have to be paid or otherwise compensated for the use of such Personal Materials, other images and materials, (ii) any rights he or she may have to control the manner of use of such Personal Materials, other images and materials, and (iii) any rights he or she may have to inspect or approve the finished product incorporating or based on, in whole or in part, the Personal Materials, other images and materials, including but not limited to photographs and printed matter that may be used as described above. Furthermore, the undersigned and his or her successors and assigns hereby release and hold Wellstar and its affiliates and their respective officers, trustees, agents and employees harmless from and against any claim for injury or compensation resulting from the activities authorized by this authorization and consent.

Signature of Individual: _____ Print Name: _____

Signature of Parent or Legal Guardian (for minors): _____

Date: _____ Wellstar Employee ID Number: _____

Phone Number: _____ E-mail: _____