

CONGRATULATIONS ON SCHEDULING YOUR FIRST APPOINTMENT WITH

PeaceHealth Medical Group Bariatrics

APPOINTMENT DATE	
ARRIVAL TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM
APPOINTMENT TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM
PROVIDER	

***PLEASE NOTE THIS APPOINTMENT TIME MAY CHANGE DEPENDING ON THE PROVIDER'S SURGERY SCHEDULE**

Contact (541) 222-2700 if you need to cancel or reschedule your appointment.

BEFORE YOUR APPOINTMENT –

Please be sure to watch our **Online Seminar Series** that is **required** for our program accreditation and attest to your attendance using the online submission form.

1. Go to www.peacehealth.org/bariatrics
2. Click the Eugene/Springfield Oregon button
3. Scroll down to the “Want to get started?” list and select the link for the videos – the Seminar is 6 videos that will take about 40 minutes to watch.
4. Complete the Online Seminar Registration form. *Smartphone users: please note the submission button may not load on the mobile webpage.* Patients will also attest to watching this seminar on the “Patient Agreement Form.”

DAY OF APPOINTMENT CHECKLIST:

Missing forms and late check ins may result in reschedules, please double check you have ALL information and are on time for check in.

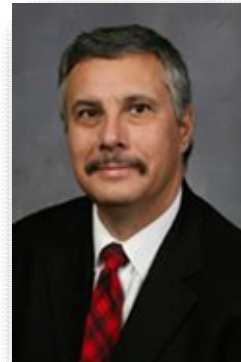
- ALL medication bottles or medication list – please update list to include:
 - All vitamins and supplements
 - Dosages and frequency that medication is taken
- Photo ID & Insurance Card
- Co-pay – payable with cash, credit/debit card, or using myPeaceHealth e-check in
- COMPLETED** Finances & Coverages Checklist – **Included in packet**
- COMPLETED** Patient Agreement Form – **Included in packet**
- COMPLETED** Initial Lab Work Form – **Included in packet**
- COMPLETED** 4pg. Health & Lifestyle Form – **Included in packet**
- Self-pay patients – COMPLETED** Cash Pricing Contract – **Included in packet**

NEW TO THE PEACEHEALTH SYSTEM?

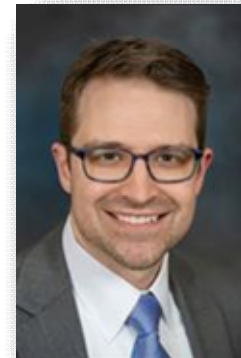
Sign up for our PeaceHealth Patient Portal at

<https://my.peacehealth.org/MyPeaceHealth/Authentication/Login?>

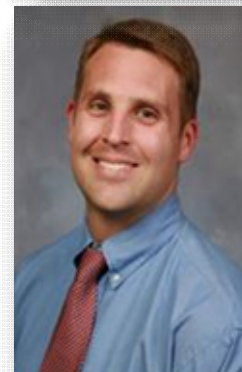
Communicate with your providers, keep an eye on labs, schedule and manage appointments, e-check in, and more!



Colin MacColl, MD
Bariatric & General Surgeon



Matthew Gust, MD
Bariatric & General Surgeon



Christopher Webb, PA
Physician Assistant



Kristina Wallace, PA
Physician Assistant

DIRECTIONS

PeaceHealth Medical Group Bariatrics & General Surgery

Riverbend Pavilion

3377 Riverbend DR. Ste. 230
Springfield, OR 97477
(541) 222-2700

Parking garage "C" is attached to the Pavilion building. **DO NOT** enter the building with the blue roof awning. A map is included on the backside of this page to help guide you; the Pavilion and parking garage "C" have been circled.

Please note: The Pavilion can only be accessed from the parking garage through the **ground floor** or the **3rd floor**.

LEVEL G

Skybridge Access on Level 3 to
NORTHWEST SPECIALTY CLINICS &
SACRED HEART MEDICAL CENTER

LEVEL 3

← Skybridge to
NORTHWEST SPECIALTY CLINICS &
SACRED HEART MEDICAL CENTER

To get to our office:

- Enter Pavilion through the **GREEN DOORS**, **DO NOT** enter through the **BLUE DOORS**, and **DO NOT** cross the sky bridge.
- Once inside, take the elevator to the **2nd floor**. Exit the elevator and continue past the Gastroenterology desk. Check in at the last desk, Suite 230.

*****PLEASE CALL (541) 222-2700 IF YOU GET LOST! *****

ENTER PAVILION THROUGH
GREEN DOORS



DO NOT USE BLUE DOORS
DO NOT TAKE SKYBRIDGE



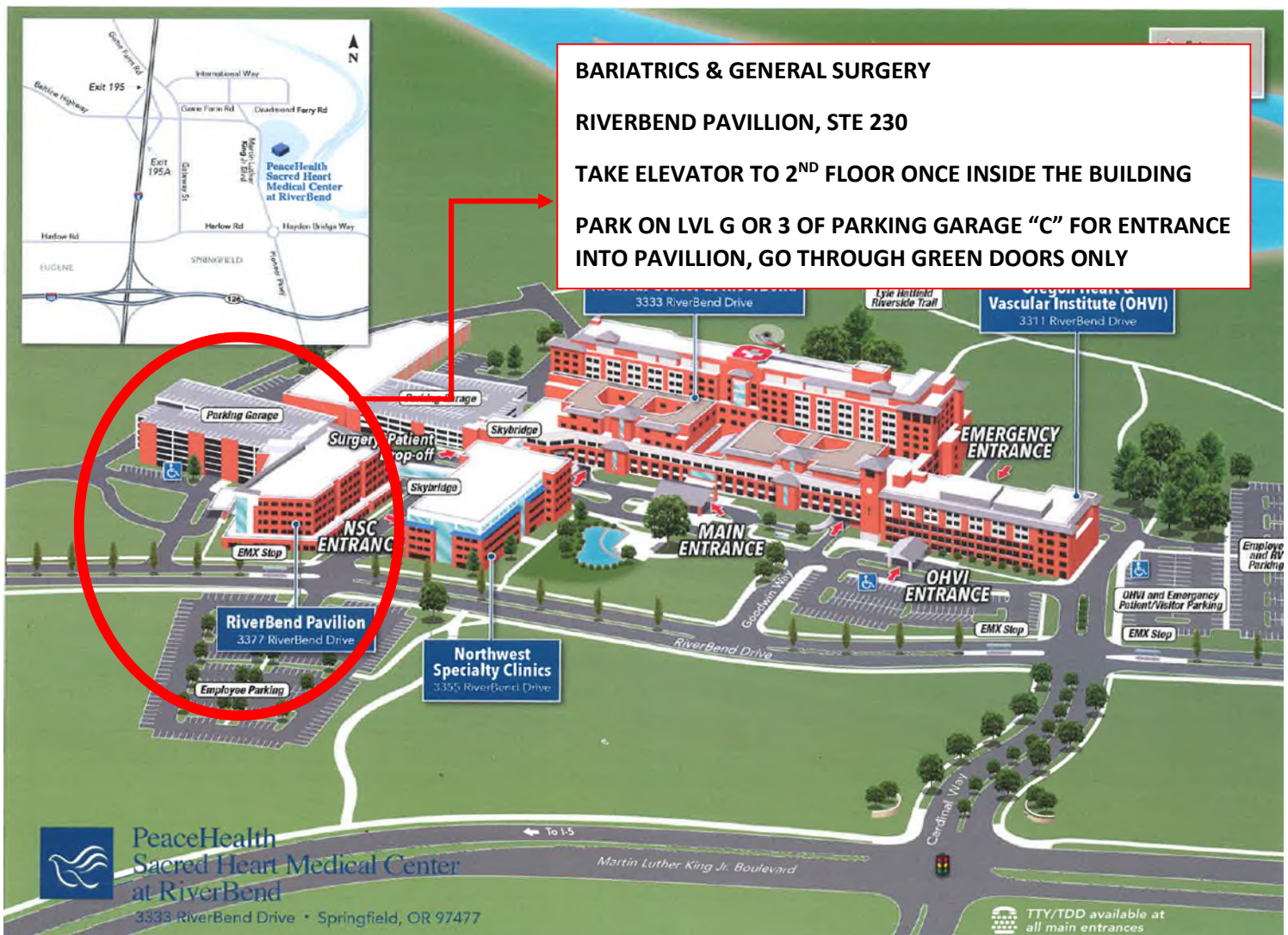
DRIVING DIRECTIONS TO RIVERBEND PAVILION

From I-5 North / South: Take exit 195A and head east onto Beltline Rd. Curve right onto Martin Luther King Jr. Parkway (0.76 mi). Turn left onto Cardinal Way (0.2 mi). Turn left onto Riverbend Dr. Turn right into the Riverbend Pavilion Driveway.

From I-105 / HWY 126 heading East: Exit Springfield City Center. Turn left onto Pioneer Parkway east. Drive to roundabout intersection with Hayden Bridge Way (0.71 mi). Stay in outside lane; exit onto Martin Luther King Jr. Parkway. Turn right onto Cardinal Way (0.2 mi). Turn left onto Riverbend Dr, then turn right into the Riverbend Pavilion driveway.

From I-105 / HWY 126 heading West: Exit Springfield City Center and turn left. Turn right at the next light onto Pioneer Parkway E. Drive to roundabout intersection with Hayden Bridge Way (0.71 mi). Stay in outside lane; exit onto Martin Luther King Jr. Parkway. Turn right onto Cardinal Way (0.2 mi). Turn left onto Riverbend Dr, then turn right into the Riverbend Pavilion driveway.

From HWY 99 heading North / South: Take Beltline Rd. East. Curve right onto Martin Luther King Jr. Parkway (0.76 mi). Turn left onto Cardinal Way (0.2). Turn left onto Riverbend Dr., then turn right into the Riverbend Pavilion Driveway.



PHMG Bariatrics Finances and Coverage Checklist

Not all labs, services required by our program, or office visits will be covered by your insurance plan. For help navigating the call to your insurance company to find out more about your benefits, please refer to section 2.

SECTION 1: FINANCIAL RESPONSIBILITIES -

By participating in the PHMG Bariatric program, I agree to the following:

1. _____ I understand it is my responsibility to verify my own coverage, benefits, co-pays, out of pocket maximums, and potential costs with my own insurance. (Please use section 2 to assist you with this call)
2. _____ I understand that I must notify PHMG Bariatrics if any changes in my insurance occur so the clinic can re-verify benefits/coverages/authorizations required for any future office visits and surgery.
3. _____ I understand that I can obtain a surgery estimate by calling Patient Financial Services (PFS) (844) 212-1049 to obtain surgery estimates – please note it will take up to 72 hrs. for a PFS rep to return your call. When prompted, leave the appropriate CPT code:
 - CPT CODES – Sleeve Gastrectomy: 43775 / Gastric Bypass: 43644****Anesthesia is provided by a separate facility and is not part of PeaceHealth. Our estimates team is unable to provide an estimate for anesthesia charges, only facility and professional (provider) charges.**
4. _____ SELF PAY PATIENTS: I have received the bariatric surgery financial information sheet and understand that all estimated surgical charges/fees must be collected, in full, as outlined in the bariatric surgery financial information sheet. As the patient, I understand that all charges must be paid no later than 2 weeks before my surgery date.

PATIENT SIGNATURE: _____ DATE: _____

SECTION 2: INSURANCE COVERAGE QUESTIONNAIRE

Use the phone number on the back of your insurance card & determine your coverage by asking the following:

1. Name of customer service representative/ date of call: _____
2. Does my policy have a bariatric benefit? Circle one: Yes No*
 - a. What procedures are covered? Mark all that apply:
 - 43775 Sleeve Gastrectomy
 - 43644 Gastric Bypass
3. Does my policy cover appointments with a dietitian? Yes No
 - a. Will I have a co-pay for diet visits? Yes \$_____ No
4. What do I need to have to qualify for surgery? Mark all that apply.
 - Pre-existing conditions such as sleep apnea, high blood pressure, or diabetes?
 - Physician supervised nutrition/exercise counseling (If yes, how many months? _____)
 - Documentation of past attempts at weight loss
 - Documentation of history of obesity (If yes, how many years? _____)
 - What is your BMI requirement? _____ kg/m²
5. What is my co-pay for a specialist office visit? _____
6. What will be my out-of-pocket expense? _____
7. Do I have to go to a specific hospital for surgery? _____
8. What is the fax number for pre-authorization? _____
9. Call Reference #: _____

***PATIENTS WITHOUT A BARIATRIC BENEFIT: Contact our office at (541) 222-2700 and request to speak with a patient coordinator if you are interested in hearing about Cash/Self Pay options.**

PHMG Bariatrics Patient Agreement Form

To be accepted into the program, please *initial* each line to show you agree to adhere to the following:

1. ____ I attest that I have watched the 6 online seminar videos on the PeaceHealth Bariatrics website.
2. ____ I acknowledge that this surgery is only a tool to achieve weight loss and I commit to establishing healthy lifestyle habits to maximize the power of this tool.
3. ____ I have called my insurance company and verified my own benefits, coverage for bariatric/weight loss surgery, dietitians, behavioral health and will do so for all future program requirements.
4. ____ I agree to establish care with a primary physician, if I am not already under the care of a primary physician, before completing all dietary visits with PHMG Bariatrics.
5. ____ I agree to read and be familiar with the patient education notebook and bring with me to all appointments.
6. ____ I agree to lose or maintain designated weight before surgery as assigned by the surgeon.
7. ____ I agree to comply with dietary guidelines and take all vitamins and minerals for life as prescribed by the surgeon and outlined in the patient education notebook.
8. ____ I agree to participate in a physical activity program/exercise after surgery.
9. ____ I agree that I am currently clean of all forms of nicotine (including smoking, chewing tobacco, nicotine replacement products, etc.) and will remain so for life.
10. ____ I agree to being clean of all forms of marijuana and will not use marijuana after surgery.
11. ____ I agree to complete required consultations, testing, labs, and classes **within one year** of starting the program.
12. ____ I understand that my surgery date is dependent on completion of all program requirements.
13. ____ I agree to avoid pregnancy for 18-24 months after bariatric surgery for the health of self.
14. ____ I understand that support group is available to me monthly for ongoing support after surgery.
15. ____ If I live more than 45 minutes from the hospital, I agree to stay in the Eugene/Springfield area for up to one week after my surgery, at the surgeon's discretion.
16. ____ I agree to follow-up with PeaceHealth Bariatric & General Surgery annually after surgery. If I move out of the state, I must establish care with another bariatric program.
17. ____ I understand that I must conduct myself in a respectful way that maintains the safety of the healthcare environment. This includes appropriate language and non-threatening behavior. I understand and agree that any misconduct can result in dismissal from the PHMG Bariatric program.

PATIENT SIGNATURE: _____ **DATE:** _____

Patient Label:

PeaceHealth Bariatric & General Surgery
Bariatric Surgery Patient Program Agreement
(Updated 9/2/2022)

1 of 1

PHMG Bariatrics Initial Lab Work Agreement Form

PHMG Bariatrics will submit lab orders to be completed at any Quest Diagnostics Lab after your bariatric evaluation appointment; ***your primary care/referring physician DOES NOT need to order these labs for you. Please notify our office if you need your orders sent to a different lab.***

Prepare for your lab work by fasting 8-12 hours (water, black coffee, clear liquid, etc. ONLY) and cease taking vitamins 48 hours prior to your blood draw.

VIT B1 (THIAMINE), WHOLE BLOOD	COMPREHENSIVE METABOLIC PANEL
VITAMIN B12 & FOLATE	PROTHROMBIN TIME
IRON DEFICIENCY PANEL	APTT
VITAMIN D, 25-HYDROXY	TSH REFLEX TO FT4 IF INDICATED
COMPLETE BLOOD COUNT, WITH AUTO	LIPID PANEL, LDL DIRECT, IF INDICATED
HEMOGLOBIN A1C	

You will be required to submit a urine sample for the following labs if you have a history of nicotine, marijuana and/or drug use **in the last 3 years**:

***ALL patients are required to complete a nicotine screen prior to submitting for surgery authorization. Gastric bypass patients will complete nicotine and toxicology screens at the start of the program and prior to submitting for surgery authorization.**

*NICOTINE & COTININE SCREEN
DRUG TOXICOLOGY SCREEN – amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, opiates, oxycodone

Please initial each line to show understanding of the following:

1. _____ I understand that if my nicotine screen is positive that I must repeat the test within 30 days.
2. _____ I understand that if my repeat nicotine screen is positive that I will be placed on a 6-month pause in program. I will be referred to PCP for smoking cessation and will need to submit a negative test to restart.
3. _____ I understand that if my marijuana screen is positive, I will have to provide a negative test before my surgery authorization can be submitted.
4. _____ I understand that if my drug screen is positive for an illegal substance or a medication for which I do not have a prescription that I will be required to wait a minimum of one year before re-applying. I know that I will be required to provide treatment documentation.
5. _____ I understand that I can be tested at any point during the program if there is suspected drug, nicotine, marijuana, or excessive alcohol use - to ensure abstinence and patient safety.

By signing below, I acknowledge that I received and reviewed the above list of required labs needed to proceed in the program and know that I have 30 days from my evaluation appointment to complete them, or I risk program inactivation.

PATIENT SIGNATURE: _____ DATE: _____

HEALTH & LIFESTYLE INFORMATION

Please mark anything that *you the patient* have experienced in your lifetime

CARDIOVASCULAR DISEASE:

- Angina/ Chest Pain
- Congestive Heart Failure
- Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE)
- High blood pressure (Hypertension) On Medication
- Heart Disease (Including heart attack, heart surgery, or abnormal cardiac testing)
- Leg edema (swelling, water retention in legs)
- Peripheral Vascular Disease/ circulation problems (Including stroke or TIA)
- Hyperlipidemia (high cholesterol level) On Medication

GASTROINTESTINAL:

- Cholelithiasis (Gallstones)
- GERD (Acid Reflux, Heartburn) On Medication Anti-reflux surgery (e.g., Nissen Fundoplication)
- Liver Disease Cirrhosis
- Abdominal Hernia

GENERAL:

- Functional Status (ability to walk): Independent With assistive device (walker, cane, etc.) Unable
- Unexplained Bleeding
- Known Bleeding Disorder _____

METABOLIC:

- Diabetes On oral medication On insulin

MUSCULOSKELETAL:

- Back Pain Fibromyalgia Musculoskeletal Problems (joint or foot pain) Gout

PSYCHOSOCIAL:

Confirmed Mental Health diagnosis

- Bipolar disorder Anxiety or panic disorder History of Eating Disorder
- Personality disorder History of psychosis Depression

Legal and/or Illegal Substance Use

Includes medicinal and recreational marijuana as well as prescription drugs

- No history of substance use.
- History of substance use. What type(s) and when last used: _____
- Currently using. What types and how often used: _____

Have you ever had treatment for substance abuse? Yes No

If yes, when and for what substance? _____

Patient Label:

PeaceHealth Bariatric & General Surgery
Bariatric Surgery Health & Lifestyle Information
(Updated 1/3/2023)
1 of 4

Alcohol Use: None Rare (yearly) Occasional (weekly to monthly) Frequent (daily)

Nicotine Use (in all forms – smoking, patches, chewing, vaping, etc.):

Never

Past/Former Date of last use: _____

Current Use:

Rare (less than monthly)

Occasional (weekly to monthly)

Frequent (daily)

What kind and how often? _____

PULMONARY:

Asthma/COPD

Obstructive Sleep Apnea On CPAP/ BiPAP

STOP-Bang Scoring Model: Complete these questions ***if you have NOT already been diagnosed*** with sleep apnea.

1. Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

2. Tired: Do you often feel tired, fatigued, or sleepy during daytime?

Yes No

3. Observed: Has anyone observed you stop breathing during your sleep?

Yes No

4. Pressure: Do you have or are you being treated for high blood pressure?

Yes No

5. BMI: Is your BMI score higher than 35?

Yes No

6. Age: Are you over 50 years old?

Yes No

7. Neck Circumference: Is your neck circumference greater than 40 cm?

Yes No

8. Gender: Are you male?

Yes No

High risk of OSA: answering yes to three or more items

Low risk of OSA: answering yes to less than three items

REPRODUCTIVE:

Menstrual Irregularities (Other than polycystic ovarian syndrome)

Polycystic Ovarian Syndrome (PCOS)

Currently using birth control If yes, what type: _____

Hormone Replacement Therapy (HRT)

Patient Label:

PeaceHealth Bariatric & General Surgery
Bariatric Surgery Health & Lifestyle Information
(Updated 1/3/2023)
2 of 4

Please list below all serious illnesses (including MRSA), injuries and hospitalizations you have experienced in adulthood:

<u>Major Illness or injury</u>	<u>Date</u>	<u>Treatment</u>

Please list all previous surgeries & procedures (including recent endoscopy and colonoscopy):

<u>Surgery/Procedure</u>	<u>Date</u>	<u>Location</u>

FAMILY HISTORY: Please indicate if someone in your family (Father, Mother, Sister, or Brother) has a history of –

	Father	Mother	Sister	Brother	Other (please list)
Bleeding disorder					
Breast cancer					
Colon cancer					
Diabetes					
Heart disease					
High blood pressure					
Kidney disease					
Obesity					
Weight loss surgery					
Other:					

WEIGHT HISTORY: Please estimate as closely as possible for all that apply

At what age did your weight become an issue for you? _____

Approximate age when you first seriously dieted: _____

Lowest Weight in Past 5 Years: _____

Highest Weight in Past 5 Years: _____

Patient Label:

DIET HISTORY: *List the diets and diet programs that you have tried*

Program	(Circle)	Date	Duration	Max Loss
Atkins / Low carb	Yes / No			
Intermittent fasting	Yes / No			
Jenny Craig	Yes / No			
Very low carb / keto	Yes / No			
Monarch	Yes / No			
Nutri-Systems	Yes / No			
Optifast	Yes / No			
Overeaters Anonymous	Yes / No			
Weight Watchers	Yes / No			
T.O.P.S.	Yes / No			
Other: _____				

List any weight loss medications that you have taken in the past:

PERSONAL STATEMENT: *In a few sentences, please tell us why you are motivated to have weight loss surgery OR why you are interested in establishing care with PHMG Bariatrics.*

Patient Label: