UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER®
UT CENTER FOR BARIATRIC & METABOLIC SURGERY

Richard M. Peterson, MD, MPH, Chief of Bariatric & Metabolic Surgery
Wayne H. Schwesinger, MD, and Kent Van Sickle, MD

Thank you for your interest in the UT Center for Bariatric and Metabolic Surgery. You have elected to discuss your bariatric surgical options with highly qualified leaders and teachers in Laparoendoscopic and General Surgery.

Our experienced surgeons currently perform:

- Laparoscopic Roux en Y Gastric Bypass
- Laparoscopic Adjustable Gastric Banding (The Lap Band)
- Laparoscopic Vertical Sleeve Gastrectomy
- Laparoscopic Revision Bariatric Surgery

You will find information about each procedure on our website: ***http://utweightloss.com***

You are asked to keep in mind that weight loss surgery is a tool used to help change behavior. It is not the answer to severe obesity. It provides a long period of time where the patient opens a window of opportunity, giving them a chance to achieve a healthy weight. If the patient has not taken the steps to make healthy lifestyle changes regarding food and exercise during that time, obesity will return.

******** Please complete ALL forms in this packet ********

Please note:

1. It is **IMPERATIVE** to complete the history as thoroughly as possible. Moving forward with surgery will depend on its completeness.
2. **We ask that you complete the packet of documents prior to your appointment. If you are unable to finish the packet we will have to delay your appointment.**
3. **Insurance approval for your surgery will depend on documentation that you provide regarding present and past medical problems, weight history and weight loss attempts with special interest in ALL previous diets, supervised and unsupervised by a healthcare provider, behavioral weight loss therapies, exercise programs, etc. to include the PAST 5 YEARS.**

Please be as thorough as possible

4. **Contact your insurance carrier (through member services) to inquire about and know your benefits for surgical weight loss procedures.**
5. **If you haven't done so already, please contact your primary care provider and arrange for a referral and copies of your medical records <u>for the past 2 years</u>.**

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Bariatric Surgery Agreement

Initial evaluation

Patients meeting program criteria will be seen for an initial evaluation with one of the listed Physicians for an introduction to the surgical weight loss (SWL) program, risks vs. benefits, procedures, patient's medical and surgical history, a limited physical exam, and review of the patient's weight loss, diet and exercise history.

Nutritional counseling

Nutritional counseling is **MANDATORY** for all surgical weight loss patients. There is minimum requirement of 2 visits prior to surgery and 2 visits after surgery. Patients may go to the licensed registered dietician of their choice with an early initial visit, and a second visit upon completion of their pre-surgical workup.

Psychiatric evaluation

Patients are required to attend a minimum of one psychiatric evaluation with a licensed psychologist/psychiatrist. Additional sessions may be useful as the individual adjusts to the major life changes that accompany weight loss surgery.

Insurance/financial responsibility

The initial evaluation/consultation and subsequent appointments will be billed to the patient's insurance (unless self-pay). The patient is responsible for the required co-payment(s) at the time of each visit. All co-payments, co-insurance and any non-covered service(s) shall be the financial responsibility of the patient.

Please contact the financial/insurance coordinator in the clinic for any questions, problems or concerns related to insurance or self-pay quotes.

Post-operatively: All clinic visits for the first 90 days AFTER surgery are packaged with the surgical procedure and are not billed. You will NOT be responsible for any co-payments during this period.

Insurance approval

<u>There is NO guarantee, implicit or explicit that weight loss surgery will be approved by your insurance company.</u> All patients need to be proactive. Patients need to communicate with their insurance company concerning specific policy and coverage information for weight loss surgery. The gastric bypass procedure code (CPT) 43846 for open (conventional incision), 43644 if laparoscopic, and 43848 Revision. The laparoscopic adjustable gastric band, "lap band", CPT code is 43770. The laparoscopic vertical sleeve gastrectomy CPT code is 43775.

Administrative fees

Administrative fees will be charged for the completion of Disability Forms, FMLA, Insurance Forms, Credit Card Forms or Employment Forms. The Administrative fee is due after the completion of these forms. The fee is $25 for the completion of any forms. All forms will take approximately 14 days for completion. This is not covered by insurances, and it is the patient's responsibility.

Post-operative follow-up schedule

Post-operative visits are critical in the success of your surgical weight loss program. As part of the Bariatric Agreement, the patient also agrees to follow up the recommended program Post-Op Instructions, (diet, exercise, counseling, ECT), post-op visit schedules, including pre-clinic lab work.

Post Op Visit Schedule
2 weeks after surgery
4 weeks after surgery
3 months after surgery
6 months after surgery
12 months after surgery
Annually for minimum of 5 years
"Pre-clinic" labs will be requested for each visit starting one-month post op.
(Labs will be done within 1-2 weeks of post-op clinic visit.)

Surgery date

Appointments to discuss the surgery date will not be made until the pre-surgical work up is completed and all documents/reports have been received and in the medical record. Final determination for surgery will be made only AFTER these documents/reports have been reviewed and discussed with you by the surgeon.

Note: Many Medical costs are tax deductible. Please visit the following website for specifics:
http://irs.gov/taxtopics/tx502.htm

I have read and discussed the above with a representative of UT Medicine San Antonio.

Patient Signature:

_____Date: _____

UT Medicine San Antonio Rep Signature:

_____Date: _____

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New Patient Information

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ Suffix (Jr, Sr, etc.) _____ Title (Mr., Mrs., Ms, Dr) _____ Sex (Circle) M / F

Date of Birth _____ Social Security Number _____ Alias or Nickname (Last, First, Middle) _____ Marital Status _____

Permanent Address _____ City _____ State _____ Zip _____ County _____ Country _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Which phone number would you like to use as your primary contact? _____

Temporary Address _____ City _____ State _____ Zip _____ County _____ Country _____

For Temporary Address, please provide: Start Date: _____ Stop Date: _____

REFERRING PHYSICIAN AND PRIMARY CARE PROVIDER (PCP) INFORMATION

What provider referred you to our clinic today? _____
Name (Last, first) Address Phone#

Name of **PCP** (Last, First) _____ Address _____ Office Phone # _____

EMPLOYMENT INFORMATION

Name of Employer _____ Employer Phone Number _____ Employer Address (Street, City, Zip Code) _____

Occupation _____ Employment Status (part-time, full-time) _____

EMERGENCY CONTACT INFORMATION

1. Name (Last, First, Middle) _____ Relationship to Patient _____ Telephone (Home, Work, Cell) _____

2. Name (Last, First, Middle) _____ Relationship to Patient _____ Telephone (Home, Work, Cell) _____

GUARANTOR (If self, please skip to insurance section)

Relationship to Patient _____ Last Name _____ First Name _____ Middle Name _____ Sex (circle) _____

Social Security Number _____ Date of Birth _____ Home Phone _____ Work Phone _____

Permanent Address _____ City _____ State _____ Zip _____ County _____ Country _____

Name of Employer _____ Employer Phone Number _____ Employer Address (Street, City, Zip Code) _____

Occupation _____ Employment Status (Part-time, Full-time) _____

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PRIMARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)

Relationship to Patient | Last Name | First Name | Middle Name | Sex (Circle)

Social Security Number | Date of Birth | Home Phone | Work Phone

Permanent Address | City | State | Zip | County | Country

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (Part-time, Full-time)

SECONDARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)

Relationship to Patient | Last Name | First Name | Middle Name | Sex (Circle)

Social Security Number | Date of Birth | Home Phone | Work Phone

Permanent Address | City | State | Zip | County | Country

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (Part-time, Full-time)

IF THIRD INSURANCE, PLEASE LIST

Name of Insurance | Subscriber | DOB

Please be ready to provide:

1. ***Your insurance card(s)***
2. ***Your driver's license or ID***
3. ***Visit co-payment***

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS, CONSENT FOR TREATMENT, AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Initials _____

I authorize UT Medicine San Antonio to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care and medical treatment.

CONSENT FOR TREATMENT

Initials _____

As a consulting adult and/or legal guardian, I agree to permit the physicians and staff of UT Medicine San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at UT Medicine San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

ASSIGNMENT OF BENEFITS

Initials _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to UT Medicine San Antonio. I understand that I am responsible to follow up with insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize UT Medicine San Antonio to release all information necessary to secure payment.

I have read the Authorization Release of Medical Records, Consent for Treatment and Assignment of Benefits.

Patient Name :_____ **Date:**_____

PRINT NAME

Signature of Patient

Or Legal Guardian :_____ **Date:**_____

Relationship to Patient: _____

Witness: _____ **Date:**_____

UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER
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Notice of Privacy Practices

Effective Date: April 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AND SIGN THE ACKNOWLEDGEMENT FORM

1. **Purpose:** The University of Texas Health Science Center at San Antonio (UT Health Science Center) and its faculty, students, residents, employees, non-employees, and its affiliates (UT Medicine Physicians Group and its clinics) follow the privacy practices described in this Notice. The UT Health Science Center maintains your health information in records that are kept in a confidential manner, as required by law. The UT Health Science Center must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

2. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with the pharmacist to discuss medications, or with radiologists or other consultants to make a diagnosis. UT Health Science Center may use your health information as required by your insurer or HMO to obtain payment for your treatment. UT Health Science Center may use and disclose your health information to improve the quality of care and for education and training purposes of UT Health Science Center students, residents, and faculty.

3. **How Will the UT Health Science Center Use and Disclose My Health Information?** Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:
   Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).
   - UT Health Science Center directories, which may include your name, general condition, and your location in the UT Health Science Center. *
   - Religious affiliation to a hospital chaplain or member of the clergy. *
   - Family members or close friends involved in your care or payment for treatment. *
   - Disaster relief agency if you are involved in a disaster relief effort. *
   - To inform you of treatment alternatives or benefits or services related to your health. *
   - Fundraising activities by the UT Health Science Center. Such information will be limited to your name, address, phone number, age, gender, insurance status, and the dates you received services at the UT Health Science Center.*
   - Appointment reminders.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
   - Health oversight activities, such as audits, inspections, investigations, and licensure.
   - Law enforcement.
   - Coroners, medical examiners, and funeral directors.
   - Organ and tissue donation.
   - Certain research projects.
   - To prevent a serious threat to health or safety.
   - To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
   - National security and intelligence activities to authorized persons to conduct special investigations.
   - Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.

- Alcohol and drug abuse information has special privacy protections. The UT Health Science Center will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; to carry out treatment, payment, and operations; or as required by law.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

4. **Your Authorization Is Required for Other Disclosures**. Except as described above, we will not use or disclose your medical information, unless you allow the UT Health Science Center in writing to do so. For example, we will not use your photographs for presentations outside the UT Health Science Center without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

5. **You Have Rights Regarding Your Health Information**. You have the following rights regarding your medical information, if requested on the form(s) provided by the UT Health Science Center:
   - **Right to request restriction**. You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment.
   - **Right to confidential communications**. You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
   - **Right to inspect and copy**. You have the right to review and obtain a copy of your medical or health record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the UT Health Science Center. The UT Health Science Center will comply with the outcome of the review.
     Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the UT Health Science Center. The UT Health Science Center is not required to accept the amendment.
   - **Right to accounting of disclosures**. You may request a list of the disclosures of your health information that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or operations within the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.
   - **Right to a copy of this Notice**. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, http://www.uthscsa.edu/hipaa/patientrights.html. A more detailed Notice is also available at this website if you would like more information about these practices.

6. **Requirements Regarding This Notice**. The UT Health Science Center is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. The UT Health Science Center may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. Each time you register at the UT Health Science Center for health services, you may receive a copy of the Notice in effect at the time.

7. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the UT Health Science Center's Privacy Officer (210/567-5212) or with the Secretary of the United States Department of Health and Human Services. We will not penalize or retaliate against you in any way for making a complaint to The University of Texas Health Science Center at San Antonio or to the Department of Health and Human Services.

Contact UT Medicine's Privacy Officer at (210) 257-1627 if:

- **You have any questions about this Notice;**
- **You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or**
- **You wish to obtain a form to exercise your individual rights described in paragraph 5.**

PLEASE BRING THE ACKNOWLEDGEMENT FORM WITH YOU TO YOUR CLINIC VISIT.

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio/UTHSCSA Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in UT Medicine San Antonio/UTHSCSA Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the UT Medicine San Antonio/UTHSCSA Patient Privacy Officer at (210) 257-1627.

✦✦✦✦✦

Authorization:

Do you authorize your immediate family member(s) to have access to your medical records/information?

☐ Yes
☐ No

If yes, please list the name(s) of the AUTHORIZED family member(s):

_____

_____

_____

_____ _____
PRINT Patient Name | If Patient Representative, PRINT name and relationship to Patient

_____ _____
Patient Signature | Patient Representative Signature

_____
Date Notice Received

_____ _____
Witness Signature | Date

✦✦✦✦✦

UT MEDICINE SAN ANTONIO
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UT Medicine at San Antonio

NOTICE FOR REQUEST OF DISCLOSURE OF SOCIAL SECURITY NUMBER

(Patient Billing and Collections)

Disclosure of your Social Security Number (SSN) is required of you in order for UT Medicine San Antonio to bill and collect for patient services under Medicare or Medicaid. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN. Failure to provide your SSN, however, may cause the insurance company to deny payment for lack of SSN. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Medicine collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have UT Medicine correct information about you that is held by UT Medicine and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Medicine at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to UT Medicine HIPAA Compliance
By mail to: 6126 Wurzbach Road San Antonio TX 78238
By e-mail to: UPGPrivacy@UTHSCSA.edu
By fax to: (210) 257-1436
In person at: 6126 Wurzbach Road San Antonio TX 78238

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

UT MEDICINE SAN ANTONIO
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UT Medicine San Antonio
Consent for Disclosure and Acknowledgement of Receipt of Notice for Social Security Number

CONSENT FOR DISCLOSURE OF SOCIAL SECURITY NUMBER FOR PATIENT BILLING AND COLLECTIONS

I hereby consent to the disclosure of my Social Security Number by UT Medicine San Antonio for the stated purpose listed on Notice.

Patient Name (please print): _____

Patient Signature: _____

Date Consent Signed: _____

Acknowledgement of Receipt of Notice of Request for Social Security Number for Patient Billing and Collections

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio's Notice of Request for Social Security Number on the date indicated. If you have any questions regarding the information in the Notice of Request for Social Security Number for Patient Billing, please do not hesitate to contact the Clinic Manager or the UTM Administrator indicated on your Notice.

Patient Name (please print): _____

Patient Signature: _____

Date Consent Signed: _____

PLEASE SUBMIT THIS PAGE TO THE FRONT DESK

UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER®
UT CENTER FOR BARIATRIC & METABOLIC SURGERY

Richard M. Peterson, MD, MPH, Chief of Bariatric & Metabolic Surgery
Wayne H. Schwesinger, MD, and Kent Van Sickle, MD

The University of Texas Health Science Center San Antonio (UTHSCSA) and UT Medicine San Antonio offer patients the ability to communicate with health care providers via electronic mail (email) for non-urgent matters. Both parties (patient and physician) must agree to this arrangement. ***No information is ever sent electronically without permission from you or your legally authorized representative.***

Appropriate uses for e-mail

Email may be used to request information and ask non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please contact your health care provider's office by telephone, call 911, or go to an emergency room.

Email may be appropriate used to send protected personal health information to

- You, for your personal use;
- Consulting physicians involved in your care;
- Assisted living centers, home health agencies, or nursing homes involved in your care;
- Pharmacies, to refill prescriptions;
- Hospitals providing you care and services;
- Physical therapist and other allied health personnel involved in your care;
- Family members involved in your care and approved by you to receive this information.

If you have an email address and would like to take advantage of this service, please discuss your wishes with your physician first. Some providers do not communicate with their patients electronically. Others may ask an associate such as a nurse or billing person to contact you based on your email.

UTHSCSA and UT Medicine San Antonio may forward email as appropriate for diagnosis, treatment, and other related reasons. As such, UTHSCSA and UT Medicine San Antonio staff other than your provider may have access to emails that you send. Such access is only to make available health care services to you. Otherwise, UTHSCSA and UT Medicine will not forward emails to anyone else without prior written authorization, except as required by law.

Keeping records of e-mail communications

Email communications will be documented in one of two ways: either as (1) an electronic note maintained in a computer system, and/or (2) a paper copy filed in your health record.

Sending email

Please include your full name and your date of birth in every e-mail message that you send to your health care provider. The subject line should include the purpose of the e-mail, for example; "Prescription Refill Request."

When you receive a message from your provider containing medical advice, please acknowledge the message with a brief reply to the provider.

If a message is ever returned because of a "bad address" please make sure that you entered the complete address as it was given to you. If you are sure that your entered the address the provider gave you, please call the provider's office and make sure you have the correct email address and that the computer system is functioning properly.

If your health care provider does not answer your e-mail in 2-3 days, contact the office by telephone.

UTHSCSA and UT Medicine San Antonio may choose to discontinue e-mail communication at any time.

Privacy and Security of email

Do not use email to send or request very sensitive information.

This includes personal information you do not want other people to know about.

UTHSCSA and UT Medicine San Antonio cannot guarantee the privacy or security of any messages being sent over the internet. Any email messages sent between UTHSCSA and/or UT Medicine San Antonio and anyone outside is exchanged over the internet. There is a potential that email sent over the internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your health care provider by email.

Authorization to use email

I have been informed of and understand the risks, benefits, and procedures involved with using email to help with my health care. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email as one form of communication with my physician, and his/her associates, technicians and other health care providers.

You will be given a copy of this signed form at your request, to keep for your records.

Patient Signature Date

Patient (or patient representative) name PRINTED

Email address – please print clearly

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Surgical Weight Loss Questionnaire

Name:		
DOB:	Age:	Gender: ☐ Male ☐ Female
Height: ____feet ____inches		Weight: _____ pounds

Number and ages of children:

_____

_____

_____

Referring physician name: _____

Referring physician address: _____

Referring physician phone: _____

Weight History:

Life Event	Age	Weight
Birth weight		
Start of high school		
High school graduation		
Marriage		
Lowest weight in past 5 years		
Highest weight in past 5 years		

List all allergies and type of reaction:

_____

_____

_____

_____

_____

_____

Name: _____

List the diets and diet programs you have tried:

Program	Year	Duration	MD Supervised	Max Weight Loss
Jenny Craig				
Nutri-Systems				
Weight Watchers				
OptiFast				
Fen/Phen/Redux				
Meridia				
Lindora				
TOPS				
O.A.				
Acupuncture				
Metabolife				
Atkins				
Pritikin				
Physician Supervised				
Other:				

Please list all serious illnesses and hospitalizations you have experienced:

Major illness/major surgery	Date	Treatment

For Female Patients

Number of pregnancies	Age of first period
Number of live births	Date of last period
Miscarriages/abortions	Tubal ligation ☐ yes ☐ no
Obstetric complications	Hysterectomy ☐ yes ☐ no
Type of birth control	Estrogen replacement therapy ☐ yes ☐ no

Name: _____

Have you had, or do you have, any of the following?

Disease or symptom	When diagnosed & testing done to diagnose
Cigarette smoking—how many packs/day?	
Beer, wine, other alcohol—how many/day?	
Marijuana, cocaine or heroin?	
Heart disease	
Stroke	
High cholesterol	
High blood pressure	
Diabetes	
Asthma	
Shortness of breath	
Trouble sleeping	
Sleep apnea	
Heartburn, esophagitis, hiatal hernia	
Belching up acid or sour fluid	
Coughing or choking at night	
Gallbladder disease	
Leakage of urine with laughing, coughing, sneezing	
Low back pain/strain/sciatica	
Pain to hips, knees, ankles, and/or feet	
Blood clot in legs or lungs	
Venous stasis disease	
Gout	
Hepatitis	
Thyroid problems	
Kidney disease	
Liver disease	
Depression, anxiety, serious psychiatric condition	

Name: _____

Please list ALL medications you currently use, including over the counter medications.

Medication	Dose	Frequency

List ALL physicians under whom you receive medical care:

Doctor Name	Specialty	Address	Phone Number

Family history:

Illness	Family Member	Family Member	Family Member
Obesity			
Diabetes			
High blood pressure			
Heart disease			
High cholesterol			
Lung disease			
Kidney disease			
Blood disorder			
Cancer			
Asthma			

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Non-Covered Services (Waiver)

Patient Name: _____ MRN: _____

Department: _____ Provider: _____

Location: _____ DOB: _____

Services Requested: _____

I understand that in the opinion of UT Medicine, the services or items that I have requested to be provided to me on _____(date(s) of service) may not be covered under my health plan because it is not deemed medically necessary for my care. I understand that the Health and Human Services Commission (HHSC) or its health-insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be medically necessary for my care.

No-Cobertura de Servicios

Entiendo que en la opinión de UT Medicine, los servicios o artículos que he solicitado que debe facilitarse a mí en _____ (fecha (s) de servicio) pueden no estar cubiertos bajo mi plan de salud debido a que no se considere médicamente necesario para mi atención. Tengo entendido que el agente de salud-asegurando determina la necesidad médica de los servicios o elementos que he solicitado y recibido. También entiendo que soy responsable del pago de los servicios o artículos que he solicitado y recibido si estos servicios o artículos están decididos a no ser médicamente necesarios para mi atención.

_____ _____

Patient or Guardian/Paciente o Guardian Date/Fecha

_____ _____

Witness/Testigo Date/Fecha

Revised on 08/20/09

UT MEDICINE SAN ANTONIO
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Wayne H. Schwesinger, MD, and Kent Van Sickle, MD

Patient Name: _____DOB: _____MRN: _____

Parent or Legal Guardian: _____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at the University of Texas Health Science Center San Antonio School of Medicine OR UT Medicine San Antonio as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital and other images may be recorded to document and assist with my care and the payment of my claim (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that the University of Texas Health Science Center San Antonio School of Medicine and UT Medicine San Antonio will own these images, but I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, website and print clinical marketing, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, website/print clinical marketing, or payment purposes, the purpose(s) must be stated below:

_____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless The University of Texas Health Science Center at San Antonio School of Medicine and UT Medicine San Antonio, its staff and employees from any and all claims or cause of action that I may have of any nature whatsoever, which in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the “Consent of Photography” form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

(Patient or Patient Representative Signature) (Date)

_____

Patient, Patient Representative Printed Name