St. Mary's Hospital

Welcome to the Bon Secours Weight Management Center program for weight loss surgery.
Phone: (804) 287-4528 Fax: (804) 281-8246

Bariatric Program Contacts

Bon Secours Surgical Specialists at St. Mary's
5855 Bremo Road, Suite 506, Medical Office Building North
Richmond, VA 23226
Phone: (804) 893-8676 Fax: (804) 285-0360

Bon Secours Surgical Specialists at St. Francis
13170 St. Francis Blvd, Suite 511, Medical Office Building Midlothian, VA 23114
Phone: (804) 423-8467 Fax: (804) 423-9406

- **Dr. Brennan Carmody**
- **Dr. Nathan Lee**
- **Dr. Craig Smith**
- **Jeannine Moss, Nurse Practitioner**
- **Erin Brown, Nurse Practitioner**
- **Stacy Gittler, Physician's Assistant**

Bariatric Patient Care Coordinators
Sindy Strickland, Sindy_Strickland@bshsi.org
Brittany Collins, CMA, Brittany_Collins@bshsi.org
Phone: (804) 287-4528 Fax: (804) 281-8246

Bariatric Program Surgery Schedulers/Insurance Verification Specialist
Wendy Tener
Phone: (804) 893-8684 Fax: (804) 287-7783
Wendy_Tener@bshsi.org

Bariatric Program Coordinator
Hilarie Surratt
Phone: (804) 893-8683 Fax: (804) 287-7783
Hilarie_Surratt@bshsi.org

Bariatric Dietitians
Jenna Schmidt
(804) 893-8089 Fax: (804) 287-7783
Jenna_Schmidt@bshsi.org

Valerie Rakes
(804) 893-8706 Fax: (804) 287-7783
Valerie_Rakes@bshsi.org

Bariatric LPC
Sasha Baier
(804) 893-8685 Fax: (804) 287-7783
Sasha_Baier@bshsi.org

Bon Secours General Surgery
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5855 Bremo Road
Medical Office Building North
Suite 506
Richmond, VA 23226
p. 804-893-8679
f. 8804-285-0360

Participating Insurance Plans and Networks

Because not all insurance plans cover Bariatric surgery and plans change frequently, we require all patients to call your insurance carrier before the first appointment to verify coverage. You can ask the following questions below to verify:

Are the physicians at Bon Secours Surgical Specialists at St. Mary's participating providers with my insurance?

1) If not, do I have out of network benefits?
2) If so, are the following surgeries a covered procedure under my plan?
    a. Laparoscopic Gastric Bypass-CPT Code 43644
    b. Sleeve Gastrectomy-CPT Code 43775
    c. SADI/Duodenal Switch-CPT Code 43845
3) Does my plan have the obesity/bariatric rider/coverage?

    Note, if you do not have the obesity/bariatric rider/coverage, your insurance company will not cover your surgery regardless of medical necessity.
4) What are the requirements that one needs to meet to qualify for surgery approval?
5) ***IF you change insurance plans in the middle of program you will be responsible for verifying coverage all over again.***

Confirmation Calling Insurance Company:

_____

Reference Number/Agent Name

_____

Date and Time

Failure to confirm insurance coverage for obesity surgery may result in a bill for the office visit(s) and surgery will likely not be approved. If your insurance does not cover obesity surgery, then you may wish to consider the St. Mary's Hospital self-pay option. Please call the office if you need more information 804-287-4528.

_____

Print Name

_____

Patient Signature Date and Time

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Bon Secours Mercy Health No Show Policy

In keeping with our values of human dignity, integrity, compassion, stewardship and service, we encourage patient compliance with showing up and on time to their scheduled appointments to help ensure continuity of care and optimum clinical outcomes.

You must arrive 15 minutes prior to your scheduled appointment time or it may result in a reschedule as there is no grace period for arriving past your scheduled appointment time.

Failure to communicate a cancellation of the scheduled appointment time will result as a "No Show" at the end of the day.

Should you, notify the practice to cancel your scheduled appointment 3 hours or less before appointment time will count as an "Late Cancellation".

Patients with 3 accumulated "No Shows" and "Late Cancellations" within a rolling 12-month period may be discharged from the practice at the discretion of the provider and operational leadership. This will apply to all appointments with Surgeons, Nurse Practitioners, Dietitians, Licensed Practical Counselor, and Nurse Visits.

Print Name: _____

Signature: _____

Date & Time: _____

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BON SECOURS

Bon Secours Surgical Specialists & Weight Management Center

PATIENT INFORMATION

PATIENT NAME: _____ _____
LAST FIRST MIDDLE DATE OF BIRTH

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAILING ADDRESS: (☐SAME AS ABOVE)_____

CITY: _____STATE: _____ ZIP CODE: _____

LANGUAGE: _____ RELIGIOUS PREFERENCE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: _____ GENDER: _____ RACE: _____ETHNICITY: _____

CONTACT PREFERENCE: ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE

EMAIL ADDRESS: _____ ☐ NO EMAIL

REFFERED BY: _____ YOUR EMPLOYER: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURANCE POLICY INFORMATION

1. PATIENT RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE NAME: _____ MEMBER ID: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____

2. PATIENT RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE NAME: _____ MEMBER ID: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____

OR

☐ SELF PAY (NO INSURANCE)

PATIENT OR LEGAL
REPRESENTATIVE SIGNATURE: _____ DATE: _____

Bon Secours

Patient Name: _____

DOB: _____

Communication Release of Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

☐ **DO NOT PROVIDE health information regarding blood work, appointments, and test results to anyone but me.**

☐ **I give permission to receive my health information regarding normal test results in a voice mail message.**

Authorized Representatives

I give permission for the following people listed to receive the following PHI elements as specified below.

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

My signature below acknowledges that I provided the information above.

Signature of Patient/Legal Guardian _____**Date** _____

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Bon Secours Surgical Specialists Health & Physical Form

PATIENT NAME:	**DOB:**	**SEX:**
LOCAL PHARMACY & ADDRESS:	**PRIMARY CARE DOCTOR:**	

Please list all ALLERGIES and Reactions -or- ☐No known drug allergies/reactions ☐LATEX ALLERGY

MEDICATIONS	**DOSAGE**	**FREQUENCY**

MEDICAL HISTORY -OR- ☐ NONE

☐Anticoagulation (blood thinners)	☐Acid indigestion (reflux, GERD)	☐Anemia (low blood count)
☐Asthma	☐Arrhythmia (irregular heartbeat)	☐Arthritis
☐CAD (heart disease)	☐Autoimmune disease	☐Diabetes
☐History of congestive heart failure	☐Chronic pain	☐Headaches
☐Chronic kidney disease	☐Depression ☐ Anxiety	☐Kidney stones
☐High Cholesterol	☐Hypertension (high blood pressure)	☐Stroke
☐Liver disease	☐Ulcers	☐Urinary issues
☐Psychiatric disorder	☐DVT (blood clots)	☐History of cancer Type: Year:
☐Thyroid disease	☐Osteoporosis	☐Bowel issues, please specify:
☐Osteopenia	☐Other	☐Sleep apnea

OPERATIONS -OR- ☐ NONE	**YEAR**	**HOSPITAL**	**SURGERON**

SOCIAL HISTORY

Do you drink alcohol? ☐Yes, if so, how often? ☐ No

Do you currently smoke? Yes, if so, how often? ☐ No ☐ Former smoker

Family Medical History (who? grandparents, parents, siblings, or children)

☐Heart disease _____	☐High blood pressure _____	☐Stroke _____	☐Diabetes _____

☐Cancer, who & what type?

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St. Mary's Hospital

Questionnaire Covering the Last 5 Years

Name_____ Date_____

PLEASE COMPLETE: INCOMPLETENESS OF THIS FORM WILL CAUSE DELAYS IN PRE-AUTHORIZATION WITH THE INSURANCE COMPANY

TYPE OF WEIGHT LOSS PROGRAM	HOW OFTEN TRIED?	HOW LONG?	WHAT RESULTS WERE OBTAINED?	APPROXIMATE YEAR THIS WAS TRIED
WEIGHT WATCHERS				
PHYSICIAN SUPERVISED DIETS-(PLEASE INCLUDE NAME OF PHYSICIAN)				
ATKINS/SOUTH BEACH				
OVEREATER ANONYMOUS				
PRESCRIPTION DIET PILLS				
BEHAVIOR MODIFICATION (PLEASE INCLUDE THE NAME OF PHYSICIAN OR THERAPIST)				
PSYCHIATRIC EVLAUATION OR THERAPY (PLEASE INCLUDE THE PHYSICIAN'S NAME) NOTE: THIS EVALUATION WILL BE REQUIRED PRIOR TO SCHEDULING SURGERY				
UNSUPERVISED DIETS				

- **Some Insurance Companies will require documentation (copies of records or letter) from the physician that had you on any type of diet. Please be prepared to provide us with this information.**

St. Mary's Hospital

Dear Patient,

One of your requirements for surgery is to write a letter addressed - "To Whom It May Concern"

This letter is for your physician and your insurance provider to review. The letter will need to explain the following:

1. Why you feel you need weight loss surgery? **2.** How long have you been overweight? **3.** How does your weight affect your daily lifestyle? **4.** What problems do you confront because of your weight? **5.** How do you feel weight loss surgery could improve your quality of life?

To Whom it May Concern,

Signature: Date:

Please call us if you have any questions at 804-287-4528.
We are here to assist you in your journey towards better health.

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