



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 Bremono 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**

**Brittany Collins, CMA, [Brittany\\_Collins@bshsi.org](mailto:Brittany_Collins@bshsi.org)**  
Phone: (804) 287-4528 Fax: (804) 281-8246

**Kristen Priest, CMA, [Kristen\\_priest@bshsi.org](mailto:Kristen_priest@bshsi.org)**  
Phone: (804) 423-8467 Fax: (804) 423-9406

**Bariatric Program Surgery Schedulers/Insurance Verification Specialist**

**Wendy Tener, [Wendy\\_Tener@bshsi.org](mailto:Wendy_Tener@bshsi.org)**  
Phone: (804) 893-8684 Fax: (804) 281-7783

**Bariatric Program Coordinator**

**Hilarie Surratt, [Hilarie\\_Surratt@bshsi.org](mailto:Hilarie_Surratt@bshsi.org)**  
Phone: (804) 893-8683 Fax: (804) 287-7783

**Bariatric Dietitians**

**Jenna Schmidt, RD, [Jenna\\_Schmidt@bshsi.org](mailto:Jenna_Schmidt@bshsi.org)**  
Phone: (804) 893-8089 Fax: (804) 287-7783

**Valerie Rakes, RD, [Valerie\\_Rakes@bshsi.org](mailto:Valerie_Rakes@bshsi.org)**  
Phone: (804) 893-8706 Fax: (804) 287-7783

**Bariatric LPC**

**Sasha Baier, LPC, [Sasha\\_Baier@bshsi.org](mailto:Sasha_Baier@bshsi.org)**  
Phone: (804) 893-8685 Fax: (804) 287-7783

**Bon Secours General Surgery  
at St. Mary's**

5855 Bremono 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:**

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Reference Number/Agent Name

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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.**

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Print Name

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Patient Signature

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Date and Time

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## **Bon Secours Surgical Specialists Bariatrics No Show, Late Cancellations, and Late arrival Department Expectations**

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 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

REFERRED 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: \_\_\_\_\_

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** \_\_\_\_\_



# Bon Secours Surgical Specialists Health & Physical Form

|                                                                                                                                                |                                                                      |                                                                    |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------|
| <b>PATIENT NAME:</b>                                                                                                                           |                                                                      | <b>DOB:</b>                                                        | <b>SEX:</b>                       |
| <b>LOCAL PHARMACY &amp; ADDRESS:</b>                                                                                                           |                                                                      | <b>PRIMARY CARE DOCTOR:</b>                                        |                                   |
| Please list all ALLERGIES and Reactions -or- <input type="checkbox"/> No known drug allergies/reactions <input type="checkbox"/> LATEX ALLERGY |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
| <b>MEDICATIONS</b>                                                                                                                             | <b>DOSAGE</b>                                                        | <b>FREQUENCY</b>                                                   |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
| <b>MEDICAL HISTORY -OR- <input type="checkbox"/> NONE</b>                                                                                      |                                                                      |                                                                    |                                   |
| <input type="checkbox"/> Anticoagulation (blood thinners)                                                                                      | <input type="checkbox"/> Acid indigestion (reflux, GERD)             | <input type="checkbox"/> Anemia (low blood count)                  |                                   |
| <input type="checkbox"/> Asthma                                                                                                                | <input type="checkbox"/> Arrhythmia (irregular heartbeat)            | <input type="checkbox"/> Arthritis                                 |                                   |
| <input type="checkbox"/> CAD (heart disease)                                                                                                   | <input type="checkbox"/> Autoimmune disease                          | <input type="checkbox"/> Diabetes                                  |                                   |
| <input type="checkbox"/> History of congestive heart failure                                                                                   | <input type="checkbox"/> Chronic pain                                | <input type="checkbox"/> Headaches                                 |                                   |
| <input type="checkbox"/> Chronic kidney disease                                                                                                | <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety | <input type="checkbox"/> Kidney stones                             |                                   |
| <input type="checkbox"/> High Cholesterol                                                                                                      | <input type="checkbox"/> Hypertension (high blood pressure)          | <input type="checkbox"/> Stroke                                    |                                   |
| <input type="checkbox"/> Liver disease                                                                                                         | <input type="checkbox"/> Ulcers                                      | <input type="checkbox"/> Urinary issues                            |                                   |
| <input type="checkbox"/> Psychiatric disorder                                                                                                  | <input type="checkbox"/> DVT (blood clots)                           | <input type="checkbox"/> History of cancer Type: Year:             |                                   |
| <input type="checkbox"/> Thyroid disease                                                                                                       | <input type="checkbox"/> Osteoporosis                                | <input type="checkbox"/> Bowel issues, please specify:             |                                   |
| <input type="checkbox"/> Osteopenia                                                                                                            | <input type="checkbox"/> Other                                       | <input type="checkbox"/> Sleep apnea                               |                                   |
| <b>OPERATIONS -OR- <input type="checkbox"/> NONE</b>                                                                                           | <b>YEAR</b>                                                          | <b>HOSPITAL</b>                                                    | <b>SURGEON</b>                    |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
|                                                                                                                                                |                                                                      |                                                                    |                                   |
| <b>SOCIAL HISTORY</b>                                                                                                                          |                                                                      |                                                                    |                                   |
| Do you drink alcohol? <input type="checkbox"/> Yes, if so, how often?                                                                          |                                                                      | <input type="checkbox"/> No                                        |                                   |
| Do you currently smoke? Yes, if so, how often?                                                                                                 |                                                                      | <input type="checkbox"/> No <input type="checkbox"/> Former smoker |                                   |
| <b>Family Medical History (who? grandparents, parents, siblings, or children)</b>                                                              |                                                                      |                                                                    |                                   |
| <input type="checkbox"/> Heart disease                                                                                                         | <input type="checkbox"/> High blood pressure                         | <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer, who & what type?                                                                                              |                                                                      |                                                                    |                                   |

## 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<br>(PLEASE INCLUDE THE NAME OF PHYSICIAN OR THERAPIST)                                                                     |                  |           |                             |                                 |
| PSYCHIATRIC EVALUATION OR THERAPY<br>(PLEASE INCLUDE THE PHYSICIAN'S NAME)<br>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.

