Advanced Southern Surgical Associates, LLC
604 N. Acadia Road, Suite 406
Thibodaux, LA 70301
(985) 446-2524 (985) 447-2329

PATIENT INFORMATION

NAME:_____ PHONE #:_____

ADDRESS:_____ CELL #:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMAIL ADDRESS: _____

SOCIAL SECURITY #:_____ DOB:_____

SEX: M F RACE: _____ Marital Status: S M D W

PATIENT EMPLOYED BY:_____ WORK NUMBER:_____

IN CASE OF EMERGENCY _____

PHONE # _____ RELATIONSHIP: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN (Family Dr.): _____

INSURANCE COMPANY:_____

POLICY #:_____ GROUP #:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATION TO PATIENT:_____ DOB:_____ SS #:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to either of the above named medical practices all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give my consent to release any and all medical information to any doctor and/or hospital of which I may be referred.

SIGNATURE ON FILE:_____ DATE:_____
(PATIENT OR LEGAL GUARDIAN)

PRIMARY CARE PHYSICIAN REFERRAL LETTER

Referring Physician: *Please complete this letter and then fax to:*
Dr. Johnny Perez @ (985)447-2329

Date: _____

Dr. Johnny Perez
Thibodaux Regional Medical Office Building
604 N. Acadia Road, Suite 406
Thibodaux, LA 70301

RE: Patient Name: _____ **DOB:** _____

Dear Dr. Perez:

The above stated patient has been under my care for _____ years and has a current BMI of _____. This patient suffers for morbid obesity complicated by associated co-morbidities as follows: *(Please circle all that apply)*

- *Obstructive sleep apnea* *Hypertension* *Hyperlipidemia* *GERD*
- *Hypercholesterolemia* *Degenerative Arthritis* *Stress Incontinence*
- *Diabetes (Type: _____)* *Cardio Respiratory Compromise* *PCOS* *Infertility* *Hirsutism*
- *Other:* _____
- _____

Due to weight, these conditions are becoming progressively less manageable or unmanageable through medicine alone. The patient has tried numerous times to lose weight on my recommendation without any success for the last _____ years. Methods include: *Please document dates and methods, especially recent efforts. (6months to 1 year) (diets, exercise programs where appropriate, pharmacology)*

_____

_____

_____

_____

It is my opinion that weight loss surgery is medically necessary as the only option to effectively treat this morbid obesity and its associated co-morbidities, which cannot be effectively managed without weight reduction.

Sincerely,

_____

MD Signature Printed Name Date

REFERRAL FOR BARIATRIC/GENERAL SURGERY

PLEASE FAX TO 985-447-2329

DATE:_____

PATIENT NAME:_____

PATIENT PHONE#:_____

PATIENT DOB:_____

REFERRING PATIENT FOR:_____

REFERRING PHYSICIAN:_____

REFERRING DR. ADDRESS:_____

REFERRING DR. PHONE:_____

REFERRING DR. FAX:_____

PHYSICIAN NPI#:_____

PHYSICIAN MEDICAID#:_____

Patient Health History

Name:_____

Patient Label

Health History Review: *(circle all that applies and complete blank lines as necessary)*

CARDIOVASCULAR:

- High blood pressure
- History of heart attack
- Irregular heart beats
- Heart murmur
- Chest pain: At rest/Activity
- History of angioplasty
- History of heart surgery
- Pacemaker
- CHF
- High cholesterol
- High triglycerides
- Blood clot in leg (DVT)
- Blockages in legs
- Blood transfusion
  - Year_____
- Known HIV exposure
- Rheumatic Fever
- Varicose veins
- Pulmonary embolism

ENDOCRINE:

- Diabetes (type 1 or type 2)
- Prediabetes
- Gestational diabetes
- Hyperthyroid (high)
- Hypothyroid (low)
- Chronic steroid use
- Cushings disease

CONSTITUTIONAL:

- Fatigue/tiredness
- Fever
- Night sweats

PULMONARY:

- Short of breath
  - at rest/with activity
- Asthma
- Emphysema
- Chronic bronchitis
- Difficulty sleeping flat
- Snoring
- Awakening at night
- Morning headaches
- Daytime drowsiness
- Observed apnea episodes
- Chronic insomnia
- Sleep apnea
  - CPAP/BiPAP

GASTROINTESTINAL:

- Difficulty chewing
- Difficulty swallowing
- Frequent nausea/vomiting
- Heartburn/reflux
- Hiatal hernia
- Ulcers
- Esophagitis
- Esophageal varices
- Esophageal strictures
- Chronic constipation
- Chronic diarrhea
- Irritable bowel syndrome
- Ulcerative colitis
- Chron's disease
- Fatty liver
- Elevated liver enzymes
- Portal Hypertension
- Hepatitis (Type A B C)
- Cirrhosis
- Chronic pancreatitis
- Gall stones
- Gall bladder disease/surgery

GENITOURINARY:

- Frequent urination
- # of night time bathroom trips:___
- Leak urine with:
  - laughter/sneezing/coughing
- Frequent bladder infections
- Interstitial cystitis
- Kidney disease

Men:

- Erectile dysfunction
- Last prostate exam_____
- Enlarged breast tissue

Women:

- Method of birth control_____
- Hysterectomy
- Ovaries removed
- Menopause
- Last menstrual period_____
- Irregular periods
- Heavy periods
- Polycystic ovarian disease
- Infertility
- Facial hair growth
- Breast cancer history
- Last pap smear_____
- Last mammogram_____
- Difficulty becoming pregnant

Health History Review: *(circle all that applies and complete blank lines as necessary)*

Patient Label

HEAD AND NECK:	SKIN:	MUSCULOSKELETAL:
Recent change in vision	Wounds that don't heal	Painful joints:
Ringing in ears	Skin cancer	shoulders/hips/knees/ankles
Vertigo	Abnormal moles	___limits ability to walk
Loss of smell	Chronic rash	___limits abililty to exercise
Hoarseness	Psoriasis/Eczema	Chronic low back pain
	Lupus	Herniated disc
NUEROLOGICAL:	Scleroderma	Where? _____
Seizures	Boils	Numbness of legs/feet
Muscle weakness	Skin infections	Joint replacement (hip/knee)
Tremors		Hernia
Narcolepsy	**PYSCHOLOGICAL:**	Type or location:_____
Stroke	Depression	Year repaired:_____
Migraines - frequency_____	Anxiety disorder	
Fibromyalgia	Suicidal thoughts	Swelling of legs/feet
Muscular Dystrophy	Suicidal attempts	Rheumatoid Arthritis
Multiple Sclerosis	Bi-polar disorder	Osteoarthritis
	Schizophrenia	Osteoporosis
	Anorexia	
	Bulimia	

Past Surgical History: *(Please list all surgical procedures and operations)*

Procedure	Date

Please indicate if there is a family history of: *(Circle all that apply)*

Obesity	Heart Disease	Bleeding Disorders
Diabetes	High Blood Pressure	Pulmonary Embolus
Breast Cancer	Colon Cancer	Lung disease, asthma, emphysema

Please list any allergies to medicine, food, or environmental triggers:

_____

_____

_____

Health History Review continued.

Patient Label

Medications: *(please list all medications and supplements you are currently taking)*

Name of Medication	Dosage	Frequency	Reason for taking this medicine

Social History:

Do you use tobacco? Yes No Years smoking:_____Years since quit?_____
Do you use alcohol? Yes No Amount and frequency:_____
Do you or have you used intravenous drugs? Yes No
Do you use recreational drugs? Yes No
If yes, name of substance and date of last usage:_____
Do you have a history of drug addiction? Yes No

Medical Testing:

When was your last chest x-ray? _____
When was your last EKG?_____
When was your last cardiac stress test?_____
Have you had blood work in the last 12 months?_____

Please sign:

(By signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge.)

Patient Signature:_____ **Date:**_____

Patient Weight History

Patient Label

Name:_____

1) **At what age did you start having weight problems?** _____

2) **What is your current weight?**_____**How long at this weight.?**_____

3) **What is your usual weight?**_____

4) **What has been your lowest weight as an adult?** _____**highest ?**_____

5) **What are your reasons for seeking weight loss now?** _____

_____

6) **Does your weight place limitations on your daily activities such as walking, tying shoes, or maintaining your personal hygiene?** (Please list the things that are diffucult for you now) _____

_____

7) **Do you have hobbies or activities you enjoy but cannot do anymore because of your weight?** _____

_____

8) **Do you think there are particular events that have caused you to gain weight in the past?** *(Please circle all that apply and list any others)*

Stress	Starting college	Fast Food	Don't like exercise
Work	Marriage/Divorce	Eating out	No time to exercise
Depression	Having children	Travel	Lack of support
Temptation	Medications	Medical reason	Illness/Health problems
Family crisis	Alcohol	Injury/Accident	Psychological problems
Busy lifestyle	Drugs	Quit smoking	Lack of will power

Other: _____

9) **What diet programs, supplements, or therapies have you tried in the past?** *(Please circle all that apply and list any others)*

Accupuncture	LA Weight loss	Slim Fast	LEARN
Atkins	Liquid diets	South beach	Quick Trim
Dietitan visit	Medifast	Sugar Busters	Others: _____
Grapefruit diet	Nutri-system	TOPS	_____
Hypnosis	Optifast	Weight watchers	_____
HMR	Pritikin diet	The Zone	_____
Jenny Craig	Regular exercise	Behavior modification	_____

10) What prescription and nonprescription medications or herbal supplements for weight loss have you taken?

Amphetamines	Metabolife	Xenical	Topamax	Laxatives
Adipex	Herbalife	Meridia	Ephedra	Other: _____
Fastin	Phen Fen	Orlistat	Dexatrim	_____
Pondimen	Redux	Sibutramine	Trimspa	_____

11) Did you have long term (>1 year) success with any of the items listed in questions 9 and 10?
If yes, please list them. _____
_____

12) How do you feel about exercise? (please circle)

Love it Like it Can tolerate it Don't like it

13) Do you currently have an activity or exercise program? Yes No
If yes, what do you like to do? (please circle or list activity)

Walking	Weights	Yoga
Bicycling	Swimming	Other: _____
Aerobics	Dancing	_____

Frequency: (circle) 1 2 3 4 5 6 7 days per week

Duration/Distance:_____

Are there reasons why you can't exercise? _____

14) How confident are you that you can lose weight at this time? (please circle)

Very Confident Confident Sort of Confident Not Confident

15) Do you have time to work on weight loss right now? Yes No Maybe

16) What is your stress level at this time? (circle the appropriate number)

High 10 9 8 7 6 5 4 3 2 1 Low

17) Do you have friends or family that you can rely on for support as you attempt to lose weight? If yes, who? _____
_____

18) What do you think will help you the most to lose weight? _____
_____
_____

19) Are you willing to make long-term changes in your behavior to lose weight? Yes No

Please sign: *(By signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge.)*

Patient Signature:_____ **Date:**_____

ADVANCED SOUTHERN SURGICAL ASSOCIATES, LLC.
604 N. Acadia, Road, Suite 406
Thibodaux, LA 70301
(985)446-2524

BARIATRIC PROGRAM CLASS POLICY

Effective Date: 01/21/2019

Bariatric surgery is an elective surgery and therefore is classified as a privilege rather than a necessity. Patients scheduled for Bariatric Surgery classes **MUST** arrive for their scheduled classes ahead of the scheduled appointment in order to be allowed into the class. Tardiness will no longer be acceptable as it is disruptive and unfair to others who have made the effort to be on time. As we understand that emergencies do arrive, you must contact the office **PRIOR** to the appointment if there is a problem arriving in adequate time to join your class. Failure to contact us is automatic dismissal from the program. Failure to arrive prior to the class starting will result in dismissal with no option of being readmitted to the Bariatric Program.

THERE WILL NO LONGER BE ANY EXCEPTIONS TO THIS RULE.

Johnny Perez, M.D.

I agree to abide by the rules above.

Print Name: _____ Date:_____

Patient's Signature:_____

Witness:_____

ADVANCED SOUTHERN
SURGICAL ASSOCIATES, LLC
JOHNNY PEREZ, M.D., Ph.D.

604. N. Acadia Road, Suite 406
Thibodaux, LA 70301
(985)446-2524

I _____, have complete understanding of the bariatric procedure which I am requesting benefits for, the risks and limitations associated with the procedure and the life-long changes in eating habits that will be required.

I _____, have the support of my immediate family and the support of my personal physician, _____.

I _____, am committed to the post-operative treatment to be provided by the bariatric program which consists of:

- a post-operative visit two week post-surgical procedure and additional follow-up visits
- reviewing nutritional status to include diet advancement, protein intake, adherence to supplements, problem foods, etc. at each visit with my physician
- reviewing exercise activity
- obtain gastric banding adjustments as needed and further follow-up
- psychological review/emotional health issues/behavior modification

I _____, agree to meet with an exercise physiologist to assess my current exercise ability and who will assist with developing an individualized exercise plan.

I _____, am committed to participating in a structured post-operative exercise and follow-up program which consists of cardiovascular exercise, resistance training and stretching/flexibility movements.

_____ _____
Date Witness

ADVANCED SOUTHERN SURGICAL ASSOCIATES, LLC
JOHNNY PEREZ, M.D., Ph.D.
General, Thoracic & Bariatric Surgery
Board Certified

Failure to provide all current insurance information, which includes primary and secondary carriers, will result in immediate dismissal as a patient from our practice.

Christina Hebert, Office Manager
Johnny Perez, M.D.

_____ _____

Patient **Witness**

604 N. Acadia Road, Suite 406 • Thibodaux, LA 70301 • Phone: (985) 446-2524 • Fax: (985) 447-2329

ADVANCED SOUTHERN
SURGICAL ASSOCIATES, LLC
JOHNNY PEREZ, M.D., PH.D.

604 N. Acadia Rd, Suite 406
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PATIENT RESPONSIBILITY AGREEMENT

I understand that if I have not provided my most current health insurance information or if my insurance carrier denies coverage for services rendered by Advanced Southern Surgical Associates or Southern Weightloss Institute, I may be financially responsible for these services and or services ordered by Advanced Southern Surgical Associates and/or Southern Weightloss Institute that are directly related to my medical care.

I also understand that my insurance may have a deductible for which I am responsible at the time of services provided.

Medicare patients will be responsible for 20% of charges which must be paid at the time of the office visit or paid in full within 30 days from receipt of billing statement for hospital charges.

I understand that if for any reason I should need emergent care and see a provider, my insurance co-pay will be due at the time of **every** visit unless under the global period of a surgical procedure.

I also acknowledge that my medical insurance policy may only provide coverage for services that are deemed medically necessary. If I receive services that my medical insurance company determines are not medically necessary, Advanced Southern Surgical Associates and/or Southern Weightloss Institute may seek payment from me for these services.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS: _____

ADVANCED SOUTHERN SURGICAL
ASSOCIATES, LLC
JOHNNY PEREZ, M.D.

604 N. ACADIA ROAD, SUITE 406
THIBODAUX, LA 70301

There is a $25.00 administrative fee assessed for any paperwork needing completion beyond the usual forms related to the actual health insurance. This fee is to be pre-paid prior to the completion of such forms.

e.g. Disability forms, Family Leave Act forms or Cancer policies.

Patient **Witness**

ADVANCED SOUTHERN SURGICAL
ASSOCIATES, LLC
JOHNNY PEREZ, M.D.

604 N. Acadia Road, Suite 406
Thibodaux, LA 70301

NOTICE FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRIVACY NOTICE
Effective Date February 1, 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

1.) **Uses and Disclosures:** Advanced Southern Surgical Associates, LLC is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment, and health care operations of the facility. For treatment purposes, such disclosures may be made to physicians, and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payers for the purpose of obtaining payment for services provided. The facility may also use personal health information to carry out day to day operations such as scheduling, appointment reminders, and quality review.

2.) **Required Authorizations:** The facility will not disclose any patient's personal health information for any purpose aside from payment, treatment, and health care operations, without the patient's authorization to disclose such. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

3.) **Privacy Compliance:** In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), the facility has adopted privacy policies regarding usage of patients' personal health information. The facility is in compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.

4.) **Additional Information:** For additional information regarding, the facility's privacy policy or for a copy of this notice, please contact our office. The facility reserves the right to change this Notice and to make the revised and changed notice effective for medical information that the facility already has about you, as well as any information the facility receives in the future. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Patient Signature:_____ **Date:**_____

HOW DO I ACCEPT OF DECLINE?

Along with this announcement, we have provided you with complete instructions on how to activate your online access to the portal as well as complete instructions on how to use the portal. Please choose to either authorize us to activate your account or decline the activation using the appropriate section below.

PORTAL ACCEPTANCE

I have read and understand the Patient Portal Announcement, the Patient Portal Online Access Instructions and the Patient Portal Guidelines & Usage Instructions and authorize Advanced Southern Surgical Associates, LLC to activate my Patient Portal Account using the email address and my Patient Portal Password in order to maintain the security and privacy of my personal health information. I also understand that Advanced Southern Surgical Associates, LLC will use the Patient Portal as a means of communicating with me when appropriate. I further understand that the Patient Portal is not to be used for urgent medical needs nor does it replace the need for me to keep my regular appointments with my doctor.

Patient Name: _____ Date of Birth: _____

Email Address: _____

Signature Date: _____

PORTAL DECLINE

I have read and understand the Patient Portal Announcement, the Patient Portal Online Access Instructions and the Patient Portal Guidelines & Usage Instructions and choose to decline the use of the Patient Portal at this time.

Patient Name: _____ Date of Birth: _____

Signature Date: _____

bioTE® MEDICAL

Male Health Assessment

Name: _____ **Date:** _____

E-Mail Address: _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Increased need for sleep or falls asleep easily after a meal					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire or in sexual performance)					
Bladder problems (difficulty in urinating, increased need to urinate)					
Erectile changes (less strong erections, loss of morning erections)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches/migraines					
Rapid hair loss or thinning					
Feel cold all the time or have cold hands or feet					
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise					
Infrequent or absent ejaculations					

Family History	**NO**	**YES**		**NO**	**YES**
Heart Disease			Alzheimer's Disease		
Diabetes			Prostate Cancer		
Osteoporosis					

bioTE® MEDICAL

Female Health Assessment

Name: _____ **Date:** _____

E-Mail Address: _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					

Family History	NO	YES		NO	YES
Heart Disease			Alzheimer's Disease		
Diabetes			Breast Cancer		
Osteoporosis					