Sparrow

Sparrow Medical Group-Bariatric Surgery

Insurance Information Worksheet

You will need to call your insurance company to ask the following questions before your first appointment at SMG Bariatrics.

Please bring this form with you to your first appointment.

1. Representative at Insurance Company (Name) _____Date of Call: _____

2. Is bariatric surgery a covered benefit? _____ YES _____ NO

3. Are procedures covered if I have surgery at Sparrow Hospital in Lansing, MI? _____YES _____NO

   Procedure Codes
   Lap Roux-en-Y Gastric Bypass: CPT Code: **43644**
   Lap Sleeve Gastrectomy: CPT Code: **43775**

   Diagnosis Code
   Morbid Obesity: ICD-10 Code: **E66.01**
   ICD-9 Code: **287.01**

4. Does my weight loss surgery benefit require a medically supervised weight loss program?

   _____ YES _____ NO If yes length of program? _____

5. What is my co-pay for a specialist care office visit? $_____

6. If Blue Cross Blue Shield, does my surgery need to be a Center of Blue Distinction? _____

7. What is my deductible per calendar year? $_____

   How much has been met? $_____

8. What is the maximum out-of-pocket cost per calendar year? $_____

   How much paid to date? $ _____

9. What is the co-insurance for bariatric surgery? $ _____

10. Does my insurance pay as inpatient or outpatient? _____ Inpatient _____ Outpatient

11. Is prior authorization required for bariatric surgery? _____ YES _____ NO

Surgery Services Program, I will be responsible for any costs related to any service I receive that may not be covered by my insurance company.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Sparrow Medical Group - Bariatric Surgery

SMG Bariatrics is a collaborative practice, and I may be assigned to EITHER surgeon

Patient Registration

Patient Name (Please print): _____ Date of Birth: _____

_____ Male _____Female Marital Status: _____S _____M _____W _____D

Primary Language: _____ Race: _____ Ethnicity:_____

Social Security # _____-_____- _____

Employment Status: _____Full Time _____Part Time _____Unemployed _____Retired

Name of Employer: _____

Email address: _____

Home Address: _____
Street City State Zip

Phone Numbers:	**Are we able to leave a detailed message?**	
Home: _____	YES	NO
Work: _____	YES	NO
Mobile: _____	YES	NO

EMERGENCY CONTACT INFORMATION (MUST Provide)

Name: _____ Relationship to you: _____

Phone Number(s):_____
Mobile Home

Insurance Information:

Primary Insurance _____ Subscriber ID _____ Group# _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance _____ Subscriber ID _____ Group# _____

Policy Holder Name: _____ DOB: _____

Insurance Co-Pay Amount? $ _____

Primary Care Physician: _____ Phone Number: _____

Patient Signature: _____ Date: _____

Sparrow Medical Group - Bariatric Surgery

2900 Hannah Blvd., Suite 216, East Lansing, MI 48823
517.364.8100

MISSED APPOINTMENT POLICY

Welcome to Sparrow Medical Group- Bariatric Surgery.

To provide quality care to our patients, improve access to and minimize waiting for appointments, our office has adopted the following policy regarding missed appointments.

By initialing below, I am attesting that I agree to and understand the expectations of SMG Bariatrics.

Initial:

_____ A telephone call made on the business day prior to the scheduled appointment is required to avoid a missed appointment fee.

_____ Cancelations and rescheduling the day of appointments are subject to missed appointment fees.

_____ Each missed appointment will result in a $50 fee.

_____ Surgical Consultation missed appointments will result in a $200 fee

_____ I understand that if I should fail to keep a scheduled appointment three (3) times in a twelve (12) consecutive month period, I will be discharged, and it will be necessary for me to make arrangements to receive my medical care elsewhere.

PLEASE NOTE: Parents and/or legal guardians will be held responsible for the appointments of minor children.

I have read the "Missed Appointment Policy" in its entirety and fully understand the information related to me and to my family members.

_____ _____

Patient Signature and Date Witness Signature and Date

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Sparrow Medical Group - Bariatric Surgery

Patient Medical History Questionnaire
(PLEASE PRINT ALL ENTRIES - THANK YOU.)

Name: Last _____ First _____ Middle Initial _____
Birth Date: _____/_____/_____
Mobile phone _____ Home phone _____Email _____
Race (please circle): White Black or African American American Indian or Alaska Native
Native Hawaiian or other Pacific Islander Asian Other: _____
Hispanic Ethnicity: Yes No Unknown
Preferred Language (please circle one): English Spanish Other: _____
Primary Care Physician (Name and Phone): _____
How did you hear about Sparrow Bariatrics? (Please circle one): Doctor Family/friend ThisTinyScar.com
Sparrow.org Other: _____

List all **allergies and the reaction:** (drugs, latex, tape, food, environment _____
_____

List all **medication names and dosages: (**include non-prescription i.e., vitamins, aspirin, fish oil, etc.):

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

List previous **surgeries** and what **year** they were performed:

1. _____ 2. _____
3. _____ 4. _____

Please list the last date you had the following test(s) and where they were completed. If you have never had one, indicate with "N/A":

Colonoscopy: _____/_____/_____ Where? _____

EKG: _____/_____/_____ Where? _____

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Sleep Study: _____/_____/_____ Where? _____

Men Only: PSA Test NO Yes _____/_____/_____

Women Only: OB/GYN exam/Pap Smear: _____/_____/_____ Where? _____
Mammogram: _____/_____/_____ Where? _____
Do you use birth control? Yes No If yes, circle type: Oral IUD Condom Diaphragm
Injection Other: _____
Any chance you are pregnant? Yes No

Social History: (Please circle one)
Current Smoker (packs/day: _____) Never Smoked Former smoker (Quit Date: _____)
Do you use smokeless tobacco? No Yes If yes, circle type: Snuff Chew Cigarette(name/brand) _____
Do you drink alcohol? No Yes If yes, _____ Glasses of wine/week _____ Cans of beer/week
_____ Shots of liquor/week _____ Other drinks w/ 0.5oz of alcohol/week
Do you use a hookah pipe or smoke hookah? No Yes
Do you smoke marijuana? No Yes If yes, how often:_____
Do you use recreational drugs: No Yes If yes, what type(s)? _____

To your knowledge, do you have now or have **you ever had** any of the following:

YES	**NO**		**YES**	**NO**	
_____	_____	Cancer	_____	_____	Arthritis
_____	_____	Diabetes	_____	_____	AIDS/HIV Positive
_____	_____	Liver Disease/Hepatitis	_____	_____	Tuberculosis
_____	_____	MRSA/VRE Infection	_____	_____	Helicobacter Pylori

Medical Information: Please check any of the following conditions from the past or present

General

_____ Fever _____ Chills _____ Night Sweats _____ Fatigue

HEENT

_____ Glasses or contacts _____ Hearing issues _____ Congestion _____ Trouble Swallowing

Pulmonary

_____ Cough _____ Wheezing _____ Snoring _____ Stop breathing while sleeping _____ Shortness of breath

_____ Emphysema/COPD _____ Asthma _____ Sleep Apnea If yes, do you use CPAP or BIPAP? No Yes

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Neurological

_____ Numbness _____ Tingling _____ Weakness _____ Seizures/Epilepsy _____ Fainting _____ Stroke/CVA/TIA
_____ Lightheadedness/Dizziness _____ Headaches

Cardiac

_____ Chest pain or pressure _____ Heart disease/failure _____ Palpitations _____ Heart murmur
_____ High blood pressure _____ Shortness of breath while lying down
_____ Heart attack If yes, date _____ (circle) Bypass Stent Angioplasty

Abdominal

_____ Pain _____ Nausea/vomiting _____ Diarrhea _____ Constipation _____ Blood in stool
_____ GERD/reflux/heartburn/indigestion _____ Difficulty swallowing _____ Stomach ulcer

Genito-urinary

_____ Urine incontinence (unintentional loss of urine) _____ Blood in urine _____ Painful urination
_____ Night time urination _____ Urgency/frequency _____ Kidney disease _____ History of kidney stones

Hematological

_____ Easy bruising _____ Easy bleeding _____ Bleeding disorder _____ Blood clots/DVT /phlebitis
_____ Blood transfusion

Musculoskeletal

_____ Muscle pain _____ Chronic low back pain _____Joint pain If yes circle all that apply: Knee Hip Ankles
Wrist Hands ____ Mobility assistance if yes, which? Cane Walker Wheelchair/scooter

Skin

_____ Rash _____ Jaundice _____ Ulcers If yes circle: Leg or sacrum _____ Cancer _____ Cellulitis

Endocrine

_____ Abnormal hair growth _____ Heat intolerant _____ Cold intolerant ____ Excessive thirst ____ Thyroid disease

Psychological Diagnosis (past or present)

_____ Anxiety _____ Depression _____ Panic Attacks _____ Bipolar Disorder _____ Eating Disorder
_____ Alcohol abuse _____ Substance abuse _____ History of self-harm/suicide attempt/homicidal thoughts

Have you had Previous Bariatric Surgery? If yes, please fill in surgery information:

____ Gastric Bypass	Date _____	Surgeon _____	Location _____
____ Sleeve Gastrectomy	Date _____	Surgeon _____	Location _____
____ Lap Band placement	Date _____	Surgeon _____	Location _____

Family History:

Have any of **your blood relatives** had any of the following (please circle: M=mother, F=father, S=Sister, B=brother, D=daughter, Sn=son):

YES	NO		YES	NO	
____	____	Obesity M F S B D Sn	____	____	Diabetes M F S B D Sn
____	____	Cancer M F S B D Sn	____	____	High Blood Pressure M F S B D Sn
____	____	Heart Disease M F S B D Sn	____	____	DVT/Blood Clot M F S B D Sn
____	____	Stroke M F S B D Sn			

Additional information for Physician:

_____

_____

_____

I hereby certify that all statements and answers provided by me in this questionnaire are true to the best of my knowledge:

Patient Signature: _____ Date: _____

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STOP-BANG Score for Obstructive Sleep Apnea

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Today's Date: _____

Circle One

Do you snore loudly? *Louder than talking or loud enough to be heard through closed doors*	NO (0)	YES (1)
Do you often feel tired, fatigued, or sleepy during the day?	NO (0)	YES (1)
Has anyone observed you stop breathing during sleep?	NO (0)	YES (1)
BMI (Body mass index)	35 or less (0)	over 35 (1)
Age	50 or less (0)	over 50 (1)
Neck Circumference	15.75 in or less (0)	Over 15.75 in (1)
Gender	Female (0)	Male (1)

TOTAL: _____

Scoring interpretation: 0-2 = low risk, 3-4 = intermediate risk, 5 or greater = high risk

Sparrow Medical Group - Bariatric Surgery

SMG Bariatrics is a collaborative practice, you may be assigned to EITHER surgeon, you do not get to choose

Program Cost Sheet

- $250 Program Fee
- $40 - MAC fitness classes (4 classes)
- Co-pays - vary based on insurance
- $277 - 2-week Pre-surgery liquid diet
- Supplements- Vitamins and minerals will be prescribed on individual basis, out of pocket costs vary
- Labs & medical clearances- each patient will require different labs and clearances. Co-pays and deductibles according to insurance plan
- Surgery – Co-pays and deductibles according to insurance plan

$250-Program Fee Cost Breakdown:

Pre-surgery body composition	Bluetooth scale
My Healthy Journey food log app	Nutrition Class 101
1st Follow-Up with Dietitian	Nutrition Class 102:
2nd Follow-Up with Dietitian	Exercise Class *(Separate from MAC Classes)
Pre-Op/Post-Op Class	Post-surgery body composition

*Program fee is due at program start and is ***Non-Refundable***. Program fees are **NOT** reimbursed by insurance. Program fee is valid for 12 months from time of payment. Patients that leave program will need to repay program fee when re-starting.

*Patients are welcome to revisit any class they have already attended for refresher at no charge. (Must be current in the program)

$277-Pre-Surgery liquid diet (product) Cost Breakdown:

Patients are on product for 2-4 weeks prior to surgery, depending on your BMI.

- $128 – Week one food items – Includes 1 box of nutrition bars, 2 boxes of product with fiber, 1 box of product without fiber and 1 can of powdered fiber
- $149 – Week 2 food items – 2 boxes of product with fiber, 2 boxes of product without fiber and one can of protein powder

**Additional product can be purchased for use before/after surgery, at additional cost, but is not required.

**If additional product is required prior to surgery, you will be notified at your surgical consult.

**Cost (cash or credit/debit card only) for product is due at time of purchase. (When surgery date is given)

Other Program Costs:

- Co-pays for provider visits according to insurance plan, payable at each visit
- Additional body composition can be requested at any time at a fee of $20
- Additional visits with Dietitian may be scheduled at patient, physician, or dietitian request. These are NOT covered by insurance. Fee is $65 per visit.

Sparrow Medical Group - Bariatric Surgery
Bariatric Insurance Coverage

We accept the following insurance plans

SPHN (Sparrow Physician Health Network)

PHP (Physicians Health Plan)

BCBS (Blue Cross Blue Shield)

BCN (Blue Care Network)

McLaren

(BCC) Blue Care Complete

Priority Health

United Health Care

Medicare

Medicaid *(Molina and Meridian not included)*

Cofinity

Aetna

When you call your insurance to see if you have coverage, please use the following billing codes:

Procedure Codes
Lap Roux-en-Y Gastric Bypass: CPT Code: 43644
Lap Sleeve Gastrectomy: CPT Code: 43775

Diagnosis Code
Morbid Obesity: ICD-10 Code: E66.01
ICD-9 Code: 287.01

Please call our office at 517-364-8100 for any further insurance questions.

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Sparrow Medical Group- Bariatric & General Surgery

Release of Medical Information Consent Form and Authorization for Disclosure of Protected Health

SMG-Bariatrics- ***may release information over the telephone*** to the following persons. (i.e., blood test or x-ray results with instructions, surgery information, appointment information, etc.) If there are no names written in this section, we **WILL NOT** be able to release any information to anyone other than **YOU**.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

SMG –Bariatrics may ***use or make a disclosure of protected health information*** (send information to/receive information from) the following of my physicians:

Primary Care Physician: _____

Cardiologist: _____

Ob/Gyn: _____

Pulmonologist: _____

Gastroenterologist: _____

Endocrinologist: _____

Psychiatrist: _____

Psychotherapist: (i.e., therapist, social worker, counselor): _____

Other: _____

It is my responsibility to notify Sparrow Medical Group- Bariatric Surgery of changes to the information given above.

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient Today's Date