

New Patient Intake Form

Patient Information				
Last Name:	First Name:			DOB:
Preferred Phone:	Email:	n.l.u.		Gender:
Emergency Contact: Emergency Contact Phone:		Relation	nsni Mai	p: rital Status:
				Tital Statos.
Occupation:		Employ	er:	
Primary Care Provider (PCP):PCP Address:				PCP Phone:
Preferred Pharmacy:			<u>-</u>	Pharm Phone:
Preferred Pharmacy Address:				
Collection of the following informati monitor and improve the quality of c			aith	agencies. This information is used to
Ethnicity: Race:				
☐ Decline Response ☐ Decli			_	Black or African American
☐ Hispanic or Latino ☐ Ame		Native		Native Hawaiian or Pacific Islander
□ Not Hispanic or Latino □ Asiar	1			White Other
Preferred Language:				
Patient Signature:				Date:
requested or to facilitate payment of	yments and deductible payment for all charge aid directly to Colum to release pertinent r fa claim.	ges not co biaDocto nedical in	vere rs fo nforr	ed by my insurance company. I or services rendered. I authorize mation to my insurance company when
Patient or Guarantor Name (Print):				
Patient or Guarantor Signature:				Date:
Notice of Privacy Practices: Acknowledge that I was provided with	-	-	tors	Notice of Privacy Practices (NOPP).
Patient Name (Print):				
Patient Signature:				Date:
If completed by a patient's personal re	•		_	
Representative (Print):				Relationship:
Representative Signature:				Date:
myColumbiaDoctors Patient Portal	Sian Un			

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

☐ Send me an invitation to join myColumbiaDoctors.

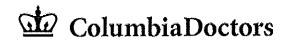
Look for an email invite from noreply@followmyhealth.org and click the Registration link.

Updated: 11/30/2015 Version 1.4b



Reason for today's vis	sit:					
General Medical Que Have you EVER had a						
Asthma/Breathing Pr	oblems 🗆 Y	οN	Heart Dise	ase/Disorder	□ Y	пN
Arthritis					0 N 0 N 0 N 0 N 0 N 0 N 0 N 0 N 0 N 0 N	
Please list any surger	ies you have had and the app	oroxim	ate date.			
Procedure Date Complications						
Please indicate any m	ajor conditions/illnesses tha	t vour	immediate f	amily members	have had:	
Relative Mother	Condition and			Living?	If deceased, at what	age?
Father				DY DN		
Sibling				OY ON		
Other:				No Yo		
Do you currently smoke?						
If yes, please list aller	gies and reactions (including	rash, l	nives, throat	swelling, anapl	iylaxis).	

Updated: 11/30/2015



Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name:		
Address:		
Phone Number:	 Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	 Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	 Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
	over the counter medications, supple Medication Name	ments, and herbs:
Medication (varie	 Medicationstance	
,		
Provider Signature:	Date:	



Please indicate ALL that you have experienced within the past 6-12 months.

General	□ None□ Feeling Tired	□ Fever □ Weight Gain	□ Chills □ Feeling Poorly □ Weight Loss
Eyes	☐ None ☐ Dry Eyes	□ Eye Pain □ Itchy Eyes	□ Vision Changes □ Eyesight Problems
Ear/Nose/Throat	□ None□ Sinus problems	□ Earache □ Sore throat	□ Loss of hearing □ Nose bleeds □ Hoarseness
Heart	□ None □ Slow heart rate	□ Chest pain□ Leg swelling	☐ Palpitations ☐ Fast heart rate ☐ Leg pain, discomfort, fatigue during walking
Lungs/Breathing	□ None □ Trouble breathin	□ Cough ng with exertion	□ Wheezing□ Shortness of breath□ Trouble breathing when lying flat
Gastrointestinal	□ None □ Heartburn	□ Abdominal pain□ Nausea	☐ Constipation ☐ Diarrhea ☐ Blood in stool
Bladder	□ None □ Pelvic pain	□ Incontinence □ Painful period	□ Discolored urine□ Painful urination□ Vaginal Discharge
Skin	□ None□ Skin lesions	□ Acne □ Skin wound	□ Itching □ Change in a mole □ Breast pain □ Breast lump
Neurological	□ None □ Limb weakness	□ Confused□ Loss of memory	□ Convulsions □ Dizziness □ Headaches □ Difficulty walking
Psychiatric	□ None □ Suicidal	☐ Anxiety☐ Disturbed sleep	□ Depression □ Change in personality □ Emotional problems
Endocrine	□ None □ Hair loss	□ Weak muscles□ Hot flashes	☐ Feeling weak ☐ Deepening of voice
Hem/Lymph	□ None	□ Easy bleeding	☐ Easy bruising ☐ Swollen glands

Updated: 11/30/2015



Additional Bariatric Information

0= Would never doze

Please circle the appropriate answer or	fill in the blank f	or the following	questions:
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1= Slight chance of dozing

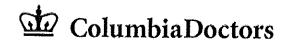
1)	1) Do you snore? Yes No Don't know It Yes: Nightly? Loudly?	
2)	2) Has anyone ever told you that you stop breathing, struggle to breathe or gasp in your sleep?	Yes No
3)	3) Do you ever wake up short of breath or gasping? No Rarely Occasionally Frequently	
4)	4) Do you have trouble falling asleep more than once a week? Yes No	
5)	5) How many times do you usually wake up during the night? 0-1 1-2 2-3 3 or n	nore
6)	6) How many times do you usually urinate during the night? 0-1 1-2 2-3 3 or n	nore
7)	7) What time do you usually get into bed at night (range is OK)? AM PM (Circle one)	
8)	8) What time do you usually get out of bed to start your day (range is OK)? AM PM (Ci	cle one)
9)	9) How many hours of total sleep do you average each night? Hours	
10)	10) Are you refreshed (not sleepy or tired) when you first get up for the day? Yes No	
11	11) Do you nap <u>on purpose</u> during the day?	
	Never Rarely (<1/mo) Sometimes (1/wk) Frequently (2 or more/wk) Daily	
12)	12) <u>Epworth Sleepiness Scale</u> : How likely are you to doze off or fall asleep in the following situation contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you h	ns, in

2= Moderate chance of dozing 3=High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in public (i.e. at a meeting or in a theater)	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without any alcohol	
In a car, while stopped for a few minutes in traffic or when you are taking mass transit	

13) Please write in any other information about your sleep that you think might be important.

Version 1.1 Updated: 11/30/2015



Most insurance companies are requesting a diet history before approving surgery. For each weight loss method, please indicate if you have tried it, the number of times you have tried that method, for how long, and the amount of weight lost.

	# of times tried:	<u>From</u> :	<u>To</u> :	Amt. WT. Lost
Weight Loss Programs:				
		•	•	
	·			
	<u> </u>	-		
Comprehensive Weight				
Loss Programs:				
		···		<u> </u>
<u>Diets</u> :				
				
		······································		
			•	
Medications:				
wicalcations.				
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	<u> </u>			
				
	· · · · · · · · · · · · · · · · · · ·	-		
Weight Loss Aides:				
	· · · · · · · · · · · · · · · · · · ·			
Other Weight Loss Methods:				
<u> </u>				

....i NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Center for Metabolic and Weight Loss Surgery 161 Fort Washington Avenue New York, NY 10032 rt. 212 305 4000 sax 212 342 1996 www.obesilymd.org

MEDICARE PRIVATE CONTRACT

HEDICAME PRIVATE CONTRACT	
This agreement is entered into thisday of	by and between
(Hereinaster called "physician"), whose principal me	dical office is located at(a patient enrolled in
Medicare Part B, hereinafter called "patient"), who resides at	
Background	
A provision in the Social Security Act permits Medicare beneficiaries and physicia the Medicare program. Under the law as it existed prior to January 1, 1998, a physiciant more than a certain percentage in excess of the Medicare fee schedule and became effective on January 1, 1998, permits physicians and patients to enter into written contract under which the patient may agree to pay the physician more than the Medicare program.	ician was not permitted to charge a nount. A new provision, which private arrangements (brough a
A "private contract" is a contract between a Medicare beneficiary and a physician opted out of Medicare for two years for all covered items and services he/she furn a private contract, the Medicare beneficiary agrees to give up Medicare payment of physician/practitioner and to pay the physician/practitioner without regard to any apply to what the physician/practitioner could charge.	ishes to Medicare beneficiates. In or services furnished by the
The purpose of this contract is to permit the patient (who is otherwise a Medicare take advantage of this new provision in the Medicare law and sets forth the rights a agreement is limited to the financial arrangement between Physician and Patient a either party to a specific course or duration of treatment.	and obligations of each. This
Patients and physicians who take advantage of this provision are not permitted to s for those services from Medicare.	submit claims or to expect paymen

Exception;

In an emergency or urgent care situation, a physician/practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a nonparticipating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner.

A. Obligations of Physician

- 1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
- 2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services anotherwise covered by Medicare.

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3. Physician acknowledges that (s)he will not execute this contract at a time when the patient is facing an omergency or urgent health care situation.

B: Obligations of Patient

C. Physician's Status

Date

- 1. Patient or his/her legal authorized representative agrees not to submit a claim (or to request that the physician submit a claim) under the Medicare program for such items or services as physician may provide, even if such items or services are otherwise covered under the Medicare program.
- 2. Patient or his/her legal authorized representative agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under the Medicare program for such items or services.
- 3. Patient or his/her legal authorized representative acknowledges that that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.
- 4. Patient acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services not paid for by Medicare.
- 5. Patient acknowledges that (s)he has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the (s)he is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
- 6. Patient acknowledges that (s)he or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

Or I Hyarvilli a Orienia				
Patient further acknowledges	his/her	understanding	that	physic

olan (bas/ has not) been excluded from

participation under the Medicare program under Section 1128. D: Term and Termination This agreement shall commence on the above date and shall continue in effect until should insert date which is two [2] years after [s]he signs the affidavit). Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both physician and patient agree that the obligation not to pursue Medicare reimbursement, for items and services provided under this contract, shall survive this contract. I have read and understand the provisions regarding private contracting. By signing this contract, I accept full responsibility for payment of the physician's or practitioner's charges for all services furnished to me from the date written above. Name of Patlent (printed) Name of Physician (printed) Signature of Physician Signature of Patient