



Indiana Obesity Center, P.C.

"defining the person within"

KEITH E MCEWEN MD

317-621-2500

317-621-2511 VM

email: cconwell@ecommunity.com

website: www.lapbandindiana.com

PATIENT INFORMATION PROFILE

Please keep this top page for our contact info:

**Please *mail* or *delivery* pages 2-10 to us with your records
and a copy of your insurance cards (if you are pursuing insurance):**

**Keith E McEwen MD
13050 Parkside Drive Suite 250
Fishers In 46038**

Program Assessment Fee: A check of \$89.50 or a charge card is required to begin scheduling appointments: We will hold these in our office if you would prefer to pay cash at the time of initial evaluation. No refunds- amount will be charged for "no show appointments or appointments not cancelled within 24 hours from time of service.

Cash discount is applied.

Name: _____ **Date of Birth** _____ **Age** _____

PERSONAL DETAILS

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No: (Home) _____ (Bus) _____ Cell _____

Occupation: _____ Social Security # _____

Email address: _____

Insurance Subscriber Name: _____ DOB _____

Insurance Name: _____ Insurance ID: _____

Membership/Group No _____ Customer Service # _____

Precertification# _____ Fax # for Precertification: _____

Mailing Address: _____

Are you financing or self-paying without insurance : _____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

Name: _____ Relationship: _____

Address: _____

Telephone No: (Home) _____ (Bus) _____

Payment Policy and Release of Information Policy

We are committed to providing you with the best possible care, we are here to assist you in all aspects of your well-being, including financial. It is your responsibility to provide us with correct and accurate information to obtain payment. It is important to understand that your insurance carrier and your insurance policy is a contract between you and your insurance carrier. We will not quote benefits or coverage for you. We will assist you during the insurance process or assist you during the financial lending process. We will provide your insurance carrier, HCFA, other physician's directly involved in your care, facilities involved in your care, and any party that you acknowledge in writing – your personal health information. All accounts are paid on demand. We are not a lending institution but we will provide you with lending institutions if the need arises or if you chose to finance your procedure. If your account is not cleared within 45 days of billing, your account information and information to contact you will be released to our collection agency, Indiana Mutual Credit Services, for recovery of fees rendered to you by our facility, surgeon, dietician, corporation, or any representative of our organization. You will be responsible for any attorney, court, collection, and/or judgement fees.

By signing below you are authorizing for these services. I hereby authorize my insurance carrier, supplemental carrier, worker's compensation, or financial lending institution to directly pay Indiana Obesity Center, Community Surgical Associates PC d/b/a Keith E McEwen MD for services rendered under for my care. I authorize this facility to release my PHI (personal health information) to those parties entitled to my information such as, other physicians, insurance carriers, short-term disability, rendering facilities, financial institutions. I understand my rights under the HIPPA Privacy Act effective 4/1/2002.

We have the right to refuse treatment within our program for non-compliance of financial responsibilities.

Signature

Date

Name: _____ Date of Birth _____ Age _____

REFERRAL INFORMATION

Where Did You hear about us: ___TV ___Newspaper ___Internet ___Friend___Brochure

Referring Doctor: _____ Date of Referral: _____

Address: _____ City: _____ State _____ Zip _____

Telephone Contact: _____ Fax# _____

Local Doctor: _____

Address: _____ City: _____ State _____ Zip _____

Telephone Contact: _____ Fax # _____

Specialist Physician/Surgeon: _____

SOCIAL PROFILE

Married: Single: Widowed: Partner/Relationship:

Children/Ages: _____

Support persons/friends: _____

Do you have a pet? If so, give details: _____

WEIGHT HISTORY

CURRENT WEIGHT: _____ CURRENT HEIGHT: _____ BMI: _____

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

Name: _____ Date of Birth _____ Age _____

WEIGHT LOSS HISTORY ATTEMPTS

Weight Watchers: _____ Duration: _____

Jenny Craig _____ Duration: _____

Nutrisystem/Gloria Marshall etc: _____ Duration: _____

Hypnotherapy: _____ Duration: _____

Fad diets: _____ Duration: _____

Appetite suppressants: _____ Duration: _____

Any other drug treatment _____ Duration: _____

Details of any other weight loss measures (including surgical- liposuction/tummy tuck):

Was there any particular event that leads to significant weight gain?

FAMILY MEDICAL HISTORY

Do you have a **family history** of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring/sleep apnea					
Asthma					
Allergies					
Hayfever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

Name: _____ Date of Birth _____ Age _____

PERSONAL HISTORY

ALCOHOL:

Do you drink alcohol? Never Rarely Regularly

How many standard glasses do you drink per day? _____ How many days per week? _____

From the list below, please check the alcoholic beverage you drink—check the one you most frequently drink.

Beer Light Beer Red Wine White Wine Sparkling Wine Fortified wine Spirits

SMOKING: (please note- smoking cessation is required prior to the band placement)

Do you smoke? Yes No Never If yes: how many per day? _____

Have you smoked in the past? Yes No If so, how many per day? _____

For how many years? _____ When did you stop smoking? _____

VITAMINS/SUPPLEMENTS:

Do you take multivitamin tablets or other dietary supplements? Yes No

If yes, how often do you take them? Rarely Monthly Weekly Most days Everyday

Please list the multivitamins or other dietary supplements you usually take:

Do you take folate tablets? Yes No

If yes, how often do you take them? Rarely Monthly Weekly Most days Everyday

FEMALES:

Do you have regular periods (26 - 33 days) Yes No If not, please describe _____

Do have problems with excessively heavy periods Yes No If Yes, please described _____

Have you had difficulty in conceiving in the past? Yes No

Do you currently have problems with infertility? Yes No

Have you suffered from excess body hair or acne? Yes No

Have you been told by a doctor that you have polycystic ovaries? Yes No

Have you had problems with pregnancy and/or childbirth? Yes No

If so, in what way _____

Have you had a caesarean section? Yes No

If so, why? _____

Have you had a tubal ligation? _____ Have you had a hysterectomy? _____

Name: _____ Date of Birth _____ Age _____

ALLERGIES (including foods, medications, dressings): Yes No

If yes, please give details: _____

SURGICAL HISTORY

Please give details of any past operations: _____

PERSONAL MEDICAL HISTORY

Have YOU ever suffered with any of the following health problems?

- Diabetes(Type I or Type II) Yes No Details: _____
- Diabetes while pregnant Yes No Details: _____
- Asthma Yes No Details: _____
- Respiratory/Breathing problems Yes No Details: _____
- Arthritis or joint pain Yes No Details: _____
- Back pain Yes No Details: _____
- Kidney or urinary disorder Yes No Details: _____
- Neurological Yes No Details: _____
- Psychological/nervous disorder Yes No Details: _____
- Gallstones Yes No Details: _____
- Reflux or heartburn Yes No Details: _____
- Gastric or duodenal ulcer Yes No Details: _____
- Hepatitis or liver disease Yes No Details: _____
- High blood pressure Yes No Details: _____
- Heart disease Yes No Details: _____
- High cholesterol Yes No Details: _____
- Anemia or bleeding disorder Yes No Details: _____
- Thrombosis or clotting disorder Yes No Details: _____
- Varicose veins or leg swelling Yes No Details: _____
- Eczema or skin condition Yes No Details: _____
- Hayfever or rhinitis Yes No Details: _____
- Tuberculosis TB Yes No Details: _____
- History of Cancer Yes No Details: _____
- History of Stroke Yes No Details: _____
- History of Epilepsy or Seizures Yes No Details: _____
- History of illicit drug use Yes No Details: _____
- Any problems with Anesthesia Yes No Details: _____
- History of Nausea after Anesthesia Yes No Details: _____

Please give details of any major illnesses/problems: _____

Name: _____ Date of Birth _____ Age _____

SLEEP HISTORY

How many hours sleep do you get a night? _____

Is there any thing else that keeps you awake at night? Yes No

Details: _____

Would you consider the quality of your sleep is Good Fair Poor

If your sleep is a major problem to you or your partner, would you be prepared to have sleep studies performed now and after you lose weight? Yes No

SYMPTOMS OF SLEEP APNEA

To answer each question, CIRCLE what best indicates your answer.

1. How often do you snore? NEVER SOMETIMES ALWAYS
2. Do you wake during the night with a choking feeling? NEVER SOMETIMES ALWAYS
3. How often would you sleep more than 8 hours in total in a 24 hour period?
NEVER SOMETIMES ALWAYS
4. How often do you wake up more than once during the night?
NEVER SOMETIMES ALWAYS
5. Do you have a headache when you wake up in the morning?
NEVER SOMETIMES ALWAYS
6. Have you noticed a reduction in your libido or sex drive?
NEVER SOMETIMES ALWAYS
7. Do you feel sleepy during the day? NEVER SOMETIMES ALWAYS
8. Has anyone noticed that you momentarily stop breathing during your sleep?
NEVER SOMETIMES ALWAYS
9. Do you fall asleep while reading? NEVER SOMETIMES ALWAYS
10. Do you wake up in the morning feeling confused? NEVER SOMETIMES ALWAYS
11. How often do you have a nap during the day? NEVER SOMETIMES ALWAYS
12. Do you feel sleepy in the evenings? NEVER SOMETIMES ALWAYS
13. Have you or anyone else noticed a change in your personality recently? NEVER SOMETIMES ALWAYS
14. How often do you doze off or fall asleep while driving? NEVER SOMETIMES ALWAYS

EMPLOYMENT

Are you currently employed? _____ Are you full-time, part-time or casual? _____

If you are unemployed, what is the reason? _____

Are you actively looking for work? _____

Has your weight made it difficult to find employment? _____

If employed, please state what level of activity your job involves:

Little (sedentary job) Moderately active Very active (Labouring, etc.)

Name: _____ **Date of Birth** _____ **Age** _____

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications.

If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Migraine medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Medications to assist weight loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Drugs for epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Drugs for asthma or breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Hormones, e.g. The Pill	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
HRT	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____
Cortisone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details _____

Please *list in detail* **all** medications that **you currently take on a daily basis** and their dosage and **your cost**: Please include any dietary supplements, cremes, eye drops, etc.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

COST: _____

Name: _____ **Date of Birth** _____ **Age** _____

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy? Yes No Details: _____

Have you ever had to change your job because it affected your breathing? Yes No Details: _____

Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?

Yes No Details: _____

ASTHMA

Have you ever had asthma? (check one of the following)

Never Current In the past Don't know

Have you ever had to spend a night in hospital because of asthma or breathing problems?

Yes No If yes was it in the last 12 months? Yes No

In the last 12 months, have you visited a hospital casualty department or seen a doctor urgently because you had asthma or breathing problems?

Yes No Details: _____

In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems?

Yes No Details: _____

In the last 12 months, have you missed work or school because of asthma or breathing problems?

Yes No Details: _____

COUGH AND SHORTNESS OF BREATH:

Do you usually have a cough? Yes No

Do you usually bring up phlegm from your chest when you cough? Yes No

Do you get short of breath on exertion? Yes No

Do you get short of breath walking on the flat? Yes No

Do you get short of breath walking uphill or doing housework? Yes No

In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause? Yes No

WHEEZE: a whistling noise that comes from the chest and may cause breathlessness or difficulty in breathing

In the last 12 months, have you had wheezing in your chest? Yes No

In the last 12 months, have you had an attack of wheezing that came after you stopped exercising? Yes No

In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning? Yes No

ACTIVITY LEVEL ~ What exercise do you do on a regular basis? _____

How many sessions of exercise (walking, sports, etc.) do you do per week for more than 30 minutes at a time?

What sort of activities? _____

How do you feel when exercising? Please mark level on scale:

1 _____ 10

Awful

Average

Excellent

Name: _____ **Date of Birth** _____ **Age** _____

GASTROESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion?

Yes No Details: _____

If yes, how often do you have reflux during the day?

Many times/day Daily Most days Most weeks Occasionally

Do you suffer heartburn / indigestion during the night? If so how often

Many times/night Nightly Most nights Most weeks Occasionally

What aggravates or causes your reflux? Details: _____

Do you have difficulty swallowing? Yes No Details: _____

Does food ever get stuck? Yes No Details: _____

Does food or fluid reflux into the mouth? Yes No Details: _____

Do you vomit with reflux? Yes No Details: _____

Do you suffer from recurrent sore throats? Yes No Details: _____

Do you suffer from a hoarse voice? Yes No Details: _____

Do you suffer from a regular cough at night? Yes No Details: _____

Please list any treatments you may use for reflux/heartburn or indigestion:

Have you had a recent Endoscopy? _____

Signature of Patient

Date

Reviewer Initials _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(please give this to your Primary Care Physician if you are requesting records)

I give my permission to release medical information to Keith E. McEwen, M.D. dba Indiana Obesity Center Or Community Surgical Associates PC

Release the following information: The entire medical record

Other _____

I hereby authorize release of such information to the above to include any and all medical records concerning my medical history, physical condition, diagnoses, treatment and/or prognosis, including X-rays and other diagnostic reports, as well as, any information contained in my medical reports or records that relate to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous or any communicable diseases, including AIDS or tests for infection with HIV, any other information related to my treatment.

This information is being requested for the following purpose:

Appointment with Dr Keith McEwen in regards to LAP BAND ® system.

This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows: Do not release information contained in my record regarding

Release only records for the dates of _____ through _____

Patient/Consenting Party Signature: _____ **Date:** _____
(Guardian or Legal Representative if patient under 18 years old)

A photocopy of a signed authorization is acceptable, providing that it is apparent that following the photocopying of the authorization on line the signature or the date is not added. This authorization is valid for sixty (60) days after the date of this request is made, unless otherwise stated. I understand this consent can be revoked at any time to the extent that disclosure is made in good faith has already occurred in reliance on this consent.

Send records to: Keith E McEwen MD
13050 Parkside Drive Suite 250
Fishers IN 46038

317-621-2511 telephones

www.lapbandindiana.com website

Lap Band Insurance Approval Guide

Our office will assist you in obtaining approval from your insurance company to provide the LAP-BAND System, but your participation in this often-lengthy process is essential. Here are some of the steps you will need to take:

- **Review your insurance policy.** Check the “Exclusion of Coverage” section for mention of weight loss surgery. Call member services and ask is Bariatric Surgery covered or excluded. Call **your member services number and ask:** is Bariatric Surgery Covered (CPT 43770) Diagnosis code 278.01 and what are the Steps to qualify for medical necessity? Write down everything and whom you spoke to!
- **Fill out consent form and give it to your PCP.** If your insurance company requires prior authorization, you will need to fill out a consent form allowing your doctor’s office to release information about your condition to your insurance company.
- **Complete the Patient Worksheet.** Fill out the information on the Patient Worksheet to assist us in the submission process. A detailed list – supported by appropriate documentation- of the specific weight loss efforts you have tried and failed in the past 5 years is necessary to show that you have been unable to achieve long-term weight loss without surgery.
- **Retrieve documents that show “medical necessity” for having the LAP-BAND System procedure.** Get copies of your medical records from your primary care physician and any other healthcare professionals who have treated your obesity and its related medical conditions (such as Type II Diabetes, high blood pressure, sleep apnea, asthma, joint problems, etc).
- **Ask your primary care physician for a letter referring you to Keith McEwen, MD for surgical weight loss.** The letter should include your height, weight, and body mass index (BMI) history, as well as any health problems you have that may be related to your obesity and the medications or treatments you are receiving for these conditions. “Failed conservative weight loss” is a keyword. Provide the sample letter for them.
- **Retrieve receipts/records that show your history of attempts to lose weight.** If you have gone to commercial weight loss centers, such as Jenny Craig® or Weight Watchers®, find your receipts and contact the centers and request copies of your records. If you have undergone medically supervised weight loss programs in the past, obtain those records. If you have never been on a medically supervised weight loss program, begin one now (while you are waiting for insurance approval for your LAP-BAND System surgery) and be sure to keep copies of your medical records. Most insurance carriers require a BMI of less than 50. Therefore, see the dietician and begin working on making your requirements.
- **Be patient.** After our office has sent your insurance company the appropriate paperwork to request pre-determination, it could take many months before a final response is received. While you are waiting to hear, investigate other available options (such as financing the cost of the procedure and making monthly payments) in case your approval is denied. Please call your carrier with questions not our office.
- **If financing, begin completing paperwork.** Your surgery can be completed within 4 weeks depending on financing and health assessment. Cheryl can provide you with contacts for approval.

Begin watching your diet, decreasing sweets, decreasing caffeine, decreasing carbonated soda, increasing water and attempting 20 minutes of daily activity. Keep a journal of everything you eat and drink. We require a 2% decrease in weight from your dietary appointment to your pre operative date. For example: Initial weight 246 = 2% would be 4 pounds.

WE WILL NOT MAKE ANY CALLS OR APPOINTMENTS UNTIL YOU COMPLETE YOUR INFORMATION ENTIRELY. FOLLOW THE STEPS ABOVE, COMPLETE, AND THEN MAIL TO US. We will not submit an insurance predetermination if fees have not been paid.

Please do not attempt to discuss your insurance or financing with Dr Keith McEwen. Questions can be directed to Cheryl. cconwell@ecommunity.com

FINANCING (these are resources- you do not have to use these recommendations):

INAMED maker of LapBand System
1-877-LAP- BAND option 4

Capital One Health Care Finance (cost is \$17,500 for LapBand System)
1-877-559-5050
www.capitalonehealthcarefinance.com

American Benefit Finance Credit
1-888-233-2234
www.abfcredit.com

Michelle Grady
National City Bank
888-242-9039 x2031

Michelle.grady@nationalcity.com

- You can use your own financing such as home equity, 401K, credit cards, personal equity line of credit, health savings accounts.
 - The cost of obesity in the United States in 2000 was more than \$117 billion.
 - In 2002, medical costs attributed to overweight and obesity reached an incredible \$92.6 billion.
 - Many insurance companies do not cover clinical or non-clinical weight-loss programs.
 - Treating an obese individual cost \$1,244 more in 2002 than treating a healthy-weight person did.
 - In 2003, Americans spent about \$75 billion in weight-related medical bills.

Overcoming morbid obesity can extend a person's life for an average of 20 years, "if you use rough numbers, and you actually multiply it out, it essentially costs less than \$2 per day to live an extra 20 years with LAP-BAND® System.

'What is your life worth to you if you had to pay for it? Is it worth \$2 a day?' To me, that is a ridiculously small price to pay." Quoted by Lee Grossbard MD, Lap Band Surgeon who also has the LapBand System.

[insert name of practice]
[insert name of physician, M.D.]
[insert address/contact information]

Sample Letter of Medical Necessity:

Give to your Primary Care Physician, Internal Medicine Physician, Endocrinologist, Orthopaedic Physician, or anyone involved in your care. Ask for him/her to mail to our office or fax to us at 317-621-2503

[insert date]

Insurance Carrier Name and Address

RE: [insert patient's name] Date of Birth:
ID#: Group#:

To Whom It May Concern:

Ms. / Mr. [insert patient's name] has been a patient of mine for [insert number] years. [Name] is [insert height] and weighs [insert weight] lbs. with a BMI of [insert patient's BMI]. My patient has been excessively overweight for over 5 years now and would benefit from Bariatric surgery. My patient meets the NIH criteria for morbid obesity.

In addition to morbid obesity, the patient is suffering from the following co morbid conditions: [insert comorbidities, e.g. exertional dyspnea, urinary incontinence, sleep apnea, hypertension, diabetes, degenerative joint disease, osteoarthritis, hypercholesterolemia, hyperlipidemia, shortness of breath, etc].

My patient has tried many methods of weight loss: i.e. including diet pills for [insert length of time] with [insert # of pounds lost and whether they were regained or not], physician administered diets for [insert # of pounds lost and whether they were regained or not], Weight Watchers®, etc. Due to limitations from comorbidities, there is an inability to exercise but has tried *[list all attempts and any successes or regaining of weight]*. In my opinion, this patient has failed conservative weight loss attempts.

Family medical history is positive for [insert medical conditions, e.g. obesity, hypertension, diabetes, etc.].

I am respectfully requesting pre-authorization for Bariatric surgery to include surgical benefits and coverage. I am referring the patient to Dr. Keith McEwen for consultation for the Laparoscopic Adjustable Gastric Banding System (LAP BAND SYSTEM ®) CPT code 43770.

Thank you for your kind consideration in this matter.

Sincerely,

[Insert name of M.D.]