Horizon Surgical, P.C.
1890 Alabama Hwy. 157
POB II, Suite 420-B
Cullman, AL 35058

Bariatric Program
Phone: (256) 736-BAND
Fax: (256) 736-2265

Dear Patient,

Thank you for your interest in Horizon Surgical's Bariatric Program. You are entering the first of several steps toward exploring whether Bariatric Surgery is the right treatment plan for you.

At Horizon Surgical, P.C., we continuously strive to provide the highest quality care possible.

The path of Bariatric Surgical Treatment is a partnership between our Practice and you. It requires diligence and commitment from us both.

The first step in pursuing Bariatric Surgery is to attend a free informational seminar. After attending the seminar, you may call our office to schedule an appointment for a physician consultation. Please bring this completed packet for the physician consultation appointment. Also, please bring a copy of your medical records for the last three years. We look forward to seeing you.

Sincerely,
Horizon Surgical, P.C.

HORIZON
SURGICAL P.C.

Horizon Surgical, P.C. **Bariatric Program**

Financial Information

Thank you for expressing an interest in the Horizon Surgical Bariatric Program. This page is intended to introduce you to the process of determining your financial ability to obtain Bariatric Surgery in our program.

- **Surgical Fee**
  - Patients with Insurance: As per insurance allows
  - For patients without insurance a set fee of **$4,000.00** (excluding complications) is available. This fee is for Horizon Surgical, P.C. only. You will encounter additional fees from the hospital, etc.

We do accept Visa, MasterCard, American Express, and all Debit Cards.

Prior to surgery you will have 3 visits (discussed in more detail below). Your first visit will be a mandatory educational seminar (free of charge) hosted by Dr. Kevin Cottingham. If you wish to proceed you will then call to make an appointment to have an in-office consult with Dr. Cottingham at a cost of $150.00 If approved for surgery, you will have a pre-op visit with Dr. Cottingham at a charge of $75.00

- I agree and understand that I am fully responsible for coinsurance, copays, and any amount not covered by my insurance carrier, regardless of what type of insurance coverage I have.
- I understand that Horizon Surgical, P.C. will attempt to precertify my surgery with my insurance company. I also understand that this process may take up to 8 weeks to complete, depending on my personal coverage in accordance with my policy. I understand that I may not be approved at all for surgery.
- There will be a $150.00 charge for the in-office consultation that is non-refundable.
- If approved for surgery, I will have a pre-op visit with Dr. Cottingham in the office before scheduling the surgery. This visit will cost $75.00
- I am aware that I will be asked to return (post-operatively) and continue follow-up visits. Depending on my personal situation, other care may be necessary. That will be determined by the physician. If you are a Private Pay (cash) patient, your post op visit/adjustments will be covered for 12 months. After your 12 months, the visits will be $55.00. If you are insured patient, your post op visit will be covered for 90 days after the date of surgery. Depending on your insurance company if they do not pay for adjustments that charge will be $55.
- I, _____have read and understand my responsibilities regarding financial payments to Horizon Surgical, P.C. I understand that payment is due at the time of visit, regardless of the outcome of my insurance filing.

Signature: _____ Date: _____

Witness: _____ Date: _____

RECENT HISTORY OF NONSURGICAL ATTEMPTS AT WEIGHT LOSS

NAME:_____

Which of the following have you tried within the last twelve months? (circle Y or N)
Please include month and year on the line below.

WEIGHT WATCHERS
Y N _____

PHYSICIAN SUPERVISED DIET
Y N _____

TOPS
Y N _____

OVEREATER'S ANONYMOUS
Y N _____

PRESCRIPTION DIET PILLS
Y N _____

PSYCHOTHERAPY
Y N _____

UNSUPERVISED DIETS (SLIMFAST, CALORIE COUNTING, ETC)
Y N _____

BEHAVIOR MODIFICATION
Y N _____

EXERCISE
Y N _____

OTHER (PLEASE SPECIFY)
Y N _____

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SURGICAL PC

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Phone: (256) 736-BAND
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Last name. First, Middle	Date of Birth Sex	Marital Status M D S W
Street Address	Home Phone	Cell Phone
City State Zip code	Work Phone	FAX Number
Employer's Name	Email Address	
Employer's Street Address	Social Security Number	Drivers License # & State
City State Zip code	Occupation	
Emergency Contact: Relationship	Cell Phone	
Street Address, City, State, ZIP	Home Phone	Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? ☐ Physician ☐ Internet ☐ Newspaper/Magazine ☐ Other

☐ Friend → Name: _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Signature: _____ Date: _____

For Office Use Only:
Date of Physical: _____ Date of Surgery: _____ Auth #: _____

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval we must have complete answers. Please be thorough. Blue or black ink only, please.

Name:		Date:	
Age:	Gender: ☐ Male ☐ Female	Occupation: (If retired, what did you do?)	
Actual Body Weight	Your Measurement	Nurse Consult Measurement	Pre-Operative Measurement
Height			
Ideal Body Weight			
Excess Body Weight			
Target Weight			
Body Frame Small Medium Large	[redacted]	BMI: Waist: Hips:	BMI: Waist: Hips:

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

LIFE EVENT	AGE	WEIGHT
Birth weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program		Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes ☐ No ☐				
Nutri-Systems	Yes ☐ No ☐				
Weight Watchers	Yes ☐ No ☐				
OptiFast	Yes ☐ No ☐				
Medi Fast	Yes ☐ No ☐				
Fen/Phen/Redux	Yes ☐ No ☐				
Meridia	Yes ☐ No ☐				
Lindora	Yes ☐ No ☐				
T.O.P.S.	Yes ☐ No ☐				
O.A.	Yes ☐ No ☐				
Acupuncture	Yes ☐ No ☐				
Metabolife	Yes ☐ No ☐				
Atkins Diet	Yes ☐ No ☐				
Pritikin Diet	Yes ☐ No ☐				

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1 Year_____ Weight at start _____ at delivery _____

Pregnancy #2 Year_____ Weight at start _____ at delivery _____

Pregnancy #3 Year_____ Weight at start _____ at delivery _____

Pregnancy #4 Year_____ Weight at start _____ at delivery _____

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from **1- like very much to 4- don't care.**

_____Soda/Soft drinks	_____French fries	_____Chips/snacks
_____Steaks/chops	_____Candy	_____Potatoes
_____Chocolate	_____Pasta	_____Cookies
_____Pizza	_____Cakes/pies	_____Salad dressings
_____Fried foods		

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes □No □

If Yes: ♦Year Diagnosed _____

Do you have, or have you had:

□ Angina
□ M.I. (myocardial infarction, "heart attack")
□ CABG (coronary artery bypass graft)
□ Abnormal EKG
□ Stress test to rule out cardiac problems
□ Palpitations

2. High Cholesterol Yes □ No □ High Triglycerides Yes□ No □

If Yes: ♦Year Diagnosed _____

♦List medications _____

3. High Blood Pressure Yes □ No □

If Yes: ♦ Year Diagnosed _____

♦List medications _____

4. Diabetes Yes □ No □

If Yes: ♦ Year Diagnosed: _____

• Gestational: Yes □ No □
• Neuropathy: Yes □ No □
• Controlled with: □ Diet
□ Oral Medication (list) _____
♦ Last fasting blood sugar: _____

5. Asthma Yes □ No □

If Yes: ♦ Year Diagnosed: _____
♦ ER visits/last 2 yrs: _____
♦ Hospitalizations last 2 years: _____
♦ Steroids last 2 years: Yes □ No □

6. Shortness of breath Yes □ No □

If Yes: ♦ Can walk _____blocks
♦ Stairs: _____ flights

7. Trouble Sleeping? Yes □ No □

♦Morning headaches Yes □ No □
♦Daytime drowsiness Yes □ No □
♦ Restless sleep Yes □ No □
♦Snoring Yes □ No □
♦Awakenings at night Yes □ No □
♦Observed apneas Yes □ No □

Office Use: L sleep study ordered _____initials

8. Sleep Apnea Syndrome Yes □ No □
If Yes: ♦ Year Diagnosed: _____
♦ Last sleep study: _____ month/year
♦ CPAP used: Yes □ No □
9. Heartburn/esophagitis/hiatus hernia? Yes □ No □
If Yes: ♦ Year Diagnosed: _____
♦ Upper GI series? Yes □ No □
♦ Endoscopy? Yes □ No □
♦Medications: _____
♦Frequency of use:_____

10. Belching up acid or sour fluid? Yes □ No □
11. Coughing or choking at night? Yes □ No □

Office Use: / *UGI/endoscopy*

12. Gallbladder disease? Yes □No □
If Yes: ♦How was it Diagnosed? □Ultrasound □Physical Exam
13. Leakage of urine with laughing/coughing/sneezing? Yes □ No □
If Yes: ♦ Wear pads frequently? Yes□ No □
14. Low back strain/Pain/Sciatica? Yes □No □
If Yes: ♦ Seen by Chiropractor? Yes □ No □
♦ Orthopedic Surgeon? Yes □ No □
♦ Seen by Family Doctor? Yes □ No □
♦ Medications taken: _____
15. Pain in Hips/Knees/Ankles/Feet? Yes □ No □
If Yes: ♦ Seen by Chiropractor? Yes □ No □
♦ Orthopedic Surgeon? Yes □ No □
♦ Seen by Family Doctor? Yes □ No □
♦ Medications taken: _____

16. Weight related injuries and trauma: _____
_____
_____

17. Venous Stasis Disease? Yes □ No □
If Yes: ♦ Do you have Edema? Yes □ No □
♦ Scaly & Thick Skin? Yes □ No □
♦ Leg Ulcers? Yes □ No □

18. Gout? Yes □ No □
If Yes: ♦Gouty Arthritis? Yes □ No □
Using Medication? _____

20. Bra size (females only): _____

Skin depressions from bra straps? Yes □ No □

Do you have shoulder pain? Yes □ No □

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

□ Measles □ Mumps □ Chickenpox □ Obesity

□ Rheumatic fever □ Heart murmur □ Asthma □ Tonsillectomy

Female Patients:

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications: _____

Do you presently use:

Birth control pills Yes □ No □ List type: _____

Estrogens Yes □ No □ List type: _____

Other Contraceptive method: _____

Serious Illnesses:

Have you had:

□ Hepatitis □ Blood Transfusion □ AIDS/HIV Exposure

□ Colitis □ Kidney Disease □ Bleeding Abnormality

□ Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness Date Treatment

_____

_____

_____

_____

Major Surgery Date

_____

_____

_____

_____

_____

_____

Allergies:

Allergic to any medications?: Yes □ No □ If Yes, please list medication and reaction:

_____

_____

Allergic to: **Surgical tape**: Yes □ No □ **Latex**: Yes □ No □ **Iodine**: Yes □ No □
Other Allergies:

_____

_____

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco: Yes □ No □ Frequency: _____
Are you willing to quit? Yes □ No □
Do you use alcohol: Yes □ No □ Frequency: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

□ Obesity
□ Diabetes
□ High Blood Pressure
□ Heart Disease
□ High Blood Cholesterol
□ Lung disease. Asthma or Emphysema
□ Kidney Disease
□ Bleeding tendency or Blood Disorder
□ Breast Cancer
□ Colon Cancer

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy Nose - runny Nose - hay fever - sinus trouble - earache - headache - blurry vision - double vision - haloes around lights - loss of night vision - buzzing in ears - ringing in ears - discharge from ear - loss of hearing - dizziness - vertigo - loss of balance - sore throat - lump in throat - trouble swallowing - pain with swallowing - hoarseness

2. RESPIRATORY: cough - wheezing - shortness of breath at night - use of two pillows - blood in sputum - out of breath with exertion - wake up at night short of breath - wake up at night coughing or choking - asthma - emphysema - bronchitis

3. CARDIOVASCULAR: palpitations - pounding heart - skipping heartbeat - pains in chest - pains in neck - pains in arms - squeezing of chest - heart attack - heart murmur - abnormal electrocardiogram - irregular heartbeat - high blood pressure - pain in legs - cold feet - blue toes - blue finger-loss of pulses

4. GASTROINTESTINAL: heartburn - nausea - vomiting - belching fluid in throat - burning in throat - food sticking in chest - pains in stomach - burning in stomach - acid stomach - diarrhea - constipation - pain with bowel movement - blood in stools - hemorrhoids - fissures - cramps - gassiness - irritable colon - colitis

5. GENITOURINARY: pain with urination - trouble starting urine - trouble stopping urine - small urine stream - blood in urine - kidney stones - bladder stones - kidney failure - nephritis - urinary tract infections - frequent urination - getting up at night to urinate - leakage of urine with cough or sneeze

•Men: discharge from penis - loss of erection - painful erection
• Women: vaginal discharge - vaginal bleeding - pain with intercourse - irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid - hyperthyroid - goiter - Grave's Disease - thyroid Nodules - xray to thyroid - diabetes - adrenal gland tumor - frequent flushing - frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints - swelling of joints - redness of skin over joints - warm joints - fluid in joints - arthritis - broken bones - sprains - low back pain - hip pain - knee pain - ankle pain - foot pain - flat feet - slipped disk - herniated disk - sciatica

8. NEUROLOGICAL: dizziness - vertigo - falling to the side - falling at night - numbness - tingling - pins and needles feelings - weakness of any muscles - twitching of muscles - weakness of grip — shakiness — tremors — fainting — convulsions - fits — loss of consciousness

9. PSYCHOLOGICAL: nervousness - anxiety - depression - thoughts of suicide - suicide attempts - hospitalization for emotional problems - psychiatric treatment - psychological counseling

Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician			
Internist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Therapist			
Other (Specify)			