317 S. 14th Street, Herrin, IL 62948
Telephone (618)988-6171 Facsimile (618)988-6174

PAPERWORK REQUIRED FOR YOUR FIRST OFFICE VISIT

All of the information listed below is required at your first office visit. This information is located in your Information Session packet. Please use this as a check list to make sure you have everything that is required.

BE AWARE that if you do not bring the necessary, completed information, your first office visit WILL BE RESCHEDULED. NO EXCEPTIONS.

- ❑ **Insurance Verification Summary & Insurance Cards – We will be taking a copy of the front and back of each card for proper billing to your insurance company at the time of your first visit.**
- ❑ **Patient Demographic Information**
- ❑ **Diet History Questionnaire** Must be filled out as completely as possible including dates and weight lost/gained.
- ❑ **Sleep History Questionnaire**
- ❑ **In addition to the completed information, you will be required to bring with you:** a photo ID and your office visit copay.

1. **You MUST bring your entire completed packet to your first office visit.**
2. **Your co-pay or applicable deductible amounts required by your insurance.**

Thank you for your cooperation in this process.

New Life **Weight Loss & Advanced Laparoscopic Surgery**
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INSURANCE VERIFICATION SUMMARY

Please place "n/a" in the blank if you are told that a certain criterion does not apply to you. You will need to fill out one of these forms for **EACH** insurance that you are covered under.

You should find the following items on your insurance card.

Patient Name: _____ **DOB**: ___/___/___

Insurance Plan: _____ **Subscriber name/DOB**: _____

ID #: _____ **Group #**: _____

Call the customer service or benefits verification number on your insurance card to obtain the following information.

(Please note, New Life Staff will not contact your insurance regarding this information)**:**

(It is always best to get at least the first name and last initial of the person you are speaking to.)

Date of Call: ___/___/___ **Time**: ___:___ am / pm **Who Did You Talk To?** _____

Please ask the follow question:

Once medical necessity is met, is Bariatric Surgery a Covered Benefit under my plan**?** Yes_____No_____

(please note, this is NOT a prior authorization for surgery) ☐Bypass ☐Sleeve ☐

If your insurance asks for a CPT code, they are as follows: Sleeve- 43775, Bypass- 43644

If your insurance asks for a diagnosis code, use E66.01- If your insurance is Healthlink call the office, as the code is BMI specific

If you have had previous bariatric surgery, you must ask if your plan will cover a second bariatric surgery procedure.

Yes _____ No_____

Patient Signature: _____ Date:_____

**** YOU MUST BRING THIS COMPLETED FORM TO YOUR INITIAL VISIT WITH NEW LIFE OR YOUR APPOINTMENT WILL BE RESCHEDULED****

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The following information is for your information only.

Deductible: Individual $_____/Family $_____ **Used**: Individual$_____/Family $_____

Out of Pocket: Individual $_____/Family $_____ **Used**: Individual $_____/Family $_____

Covered 100% after Out of Pocket Maximum is met? YES NO

Annual Benefit Maximum: $_____ **Used**: $_____ **If Contract Year, Dates:** ___/___/___ to ___/___/___

BENEFIT SUMMARY

Specialist Office Visit Copay: $___.___ **Outpatient Facility Copay:** $_____.___ **Inpatient Facility Copay:** $_____.___

If your insurance will not cover bariatric surgery, you will need to sign a self-pay agreement at your initial visit with New Life should you wish to proceed.

SIH New Life Weight Loss

Patient Demographic Information

Date

Name

Age | Date of Birth | Social Security # | ☐ Male ☐ Female

Ethnicity ☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Contact information *Check box next to phone numbers where messages can be left.*

☐ Home Phone | ☐ Cell Phone | ☐ Work Phone

Address | City/State/Zip

Email

Height | Weight | BMI *Please be as accurate as possible to prevent any delays in meeting your needs.*

I am interested in having ☐ Gastric Bypass Surgery ☐ Sleeve Gastrectomy ☐ Loop DS ☐ Undecided

Have you had a previous bariatric procedure? ☐ Yes ☐ No If yes, when and what type of procedure?

Have you previously watched an Information Session with New Life Weight Loss? ☐ Yes ☐ No | If yes, when?

How did you hear about us? (Please check all that apply)

☐ Friend Referral ☐ Television Ad ☐ Print Ad ☐ Online Search ☐ Radio Ad ☐ Facebook Ad

☐ Physician Referral | ☐ Other

Primary Care Physician and/or Referring Physician

Occupation | Employer

Insurance *If you plan on receiving assistance from your insurance company, please provide the following information.*

Insurance Provider | Insurance Provider Phone #

Policy # | Name of Insured | Date of Birth of Insured

Signature X _____

New Life Weight Loss Center Diet History Questionnaire

How old were you when you started to diet? _____

What is the maximum amount of weight you have lost at one time? _____ lbs.

How long were you able to keep the weight off? _____

What method did you use to lose the weight? _____

What surgical procedure are you interested in? Sleeve Bypass SADI-S Unsure

Diet History

Do you binge eat? Yes / No

Use laxatives to lose weight? Yes / No

Have you ever tried any of the following diets? If yes, please indicate the approximate start and end dates, weight loss and weight regain

Medi-Fast	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Opti-Fast	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Weight Watchers	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Jenny Craig	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Fen/Phen	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Phentermine/Fastin/Adipex	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Slimfast	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Behavior Therapy / Psychotherapy	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Exercise Programs	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Atkins Diet	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Intermittent fasting	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Keto diet	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Low Calorie	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
High Protein	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
South Beach	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____
Other: _____	Yes / No	Start:_____	Stop:_____	Pounds lost:_____	Pounds regained:_____

New Life Weight Loss Sleep History Questionnaire

SIH

Please indicate how likely you are to doze off during the following activities:

Sitting and reading	Never	Slight chance	Moderate chance	High Chance
Watching to	Never	Slight chance	Moderate chance	High Chance
Sitting, inactive in a public place (e.g. a theater or a meeting)	Never	Slight chance	Moderate chance	High Chance
As a passenger in a car for an hour without a break	Never	Slight chance	Moderate chance	High Chance
lying down to rest in the afternoon when circumstances permit	Never	Slight chance	Moderate chance	High Chance
sitting and talking to someone	Never	Slight chance	Moderate chance	High Chance
sitting quietly after a lunch without alcohol	Never	Slight chance	Moderate chance	High Chance
in a car while stopped for a few minutes in traffic	Never	Slight chance	Moderate chance	High Chance

Do you experience any of the following symptoms? (Please circle)

Loud snoring	Yes	No
Daytime Sleepiness	Yes	No
Difficulty falling asleep	Yes	No
Difficulty staying asleep	Yes	No
Awaken too early	Yes	No
Inability to concentrate	Yes	No
Fatigue	Yes	No
Morning headaches	Yes	No
Irritability/Depression	Yes	No
Sleep talking or walking	Yes	No
Do you have sinus symptoms interfering with sleep?	Yes	No
Heartburn, indigestion, or have a sour taste in your mouth	Yes	No
Experience the inability to move while going to sleep or waking up	Yes	No
Have vivid or life-like visions (people in room, etc)	Yes	No
Experience a creeping/crawling sensation in your legs before falling asleep	Yes	No
Experience a sudden weakness or feel your body go limp when angry or excited	Yes	No
Have an irristible urge to move your arms or legs	Yes	No
Do your arms/legs jerk during sleep	Yes	No
Frequent urination disrupting sleep	Yes	No
I worry that I won't be able to fall asleep	Yes	No

New Life Weight Loss Sleep History Questionnaire

What time do you usually go to bed? _____ a.m. / p.m.

How long does it take to fall asleep after lights out? _____

How many times do you wake up through the night? _____

Total time spent awake in bed? _____

What time do you usually wake up for the day? _____

Total length of naps daily? _____

Do you work a rotating shift? _____

Do you have an unusual work schedule? _____