



Weight Management Program

Patient Packet

The questions asked on the following pages are very important. Please fill out the packet completely. The information you provide will be used by your surgeon's office to submit your case to insurance for approval of your surgery. Thank you.

Welcome to the Mercer Health Weight Management Program. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are many steps leading up to weight loss surgery, so we have developed a multidisciplinary team to help you. It is very important that you take an active role during this process. Your effort will ensure the process moves as efficiently as possible.

In order to provide you with the best possible service, we must have the following information on file before scheduling your appointment in the Weight Management Center. You may use this sheet as a checklist for your items.

- The Weight Management Patient Packet:** Complete all forms and provide all necessary information to take the next steps in the program.
- Insurance cards:** Include copies of **any/all** insurance cards, front and back.
- Medical Records:** Ask your doctor for the last 12 months of your medical records. These are the notes in your chart that the doctor makes during your visit. Ask your doctor for copies of your medical records that support your history of obesity and any diseases you have been treated for related to obesity.
- Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved.** This means you will need to see your doctor/ dietitian every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement.
- Physician letters of support:** Ask your primary care physician or any other physicians you have seen, such as cardiologists, pulmonologists, obstetricians/gynecologists, orthopaedic specialists, to write a letter of support. (See sample letter attached.)

Please bring the completed packet, copies of your insurance cards, medical records and letters with you when you attend an information seminar, or mail the information to the address below. If you have any questions, call the Weight Management Center at 419-678-8446 (thin).

We look forward to assisting you. Send completed information to:

Mercer Health Weight Management Center
800 West Main Street
Coldwater, OH 45828
Telephone: 419-678-8446
Fax: 419-678-5240

INSURANCE INFORMATION

**PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH FRONT & BACK,
WHEN SUBMITTING THIS FORM.**

Disclaimer:

- The Mercer Health Weight Management Center is not responsible for incorrect information that the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form also does not mean that you are approved for weight loss surgery. A surgical preapproval can only be obtained once the necessary documentation is sent to the insurance company by a bariatric surgeon.

PLEASE PRINT CLEARLY

Fill in this information.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	
Provider Telephone Numbers (listed on back of card)	

Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved. This means you will need to see your doctor/ dietitian every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) do not meet this requirement.

We will verify if your policy includes a medically supervised weight loss requirement and communicate this information to you. You may call the customer service number listed on your card to determine if you need this, and begin seeing your doctor every month for six months to help speed the process along. ***We do recommend that you contact the customer service number on your card in order to better understand the benefits specific to your insurance policy. Submission for approval for surgery does not occur until after the surgeon consult, and all required information is submitted to the insurance company.***

Some insurance policies have contract exclusions which mean that weight loss surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying that it is not covered in your contract and they will not pay for it. Cash pay information is available by request. If you have questions regarding your insurance, please call the Weight Management Center at 419-678-8446.

AUTHORIZATION TO RELEASE MEDICAL RECORD

I hereby authorize release of my medical records:

TO: _____ Phone: _____

Address: _____ Fax: _____

FROM: _____ Phone: _____

Address: _____ Fax: _____

At my request, purpose for release:

Personal Continuing Care Insurance Legal Marketing Other: _____

All Records

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information.

This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without prejudice.

I may revoke this authorization at any time providing I notify Mercer Health Weight Management Center, in writing to this effect.

I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original.

Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

This form must be completely filled out to process

Patient Signature

Date

Parent/Guardian/Power of Attorney/Personal Representative

Date

Records prepared or transmitted/mailed by

Date

SAMPLE PHYSICIAN LETTER OF SUPPORT

Please obtain a letter of support from your primary care physician.

This form is a sample only and will not be accepted if the blanks are completed. Your physician must provide a separate letter of support.

Date

PHYSICIAN NAME
ADDRESS
CITY, STATE ZIP CODE

RE: PATIENT NAME
DATE OF BIRTH:

To Whom It May Concern:

The above named patient has been seen by our office for (____) years. (He/she) suffers from the following co-morbidities: (List any diseases related to obesity such as hypertension, diabetes, sleep apnea, degenerative joint disease, etc.) (His/her) current weight is (____lbs), height: (____) and BMI: (____). The patient has undergone the following weight loss attempts: (List any previous attempt, including Weight Watchers, Jenny Craig, Nutri-System, Slim Fast, etc., or any therapies you have prescribed).

I feel this patient would benefit from weight loss surgery because (he/she) has been unsuccessful losing weight with other diet methods, and (his/her) medical conditions will become life threatening if (he/she) does not get (his/her) weight under control.

I appreciate your consideration. Please contact me for further questions.

Sincerely,

Physician Name

PHYSICIAN INFORMATION

Referring or Primary Care Physician Name:	Phone:
Address/City/State/Zip:	Fax:

Please list any other physicians whose care you are under.

	Name	Address	Phone
Cardiologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Pulmonologist			
Therapist			
Other			

Reminder:** If your insurance company requires a **six month physician supervised medical weight management program** before surgery is approved, your family physician can assist you with this. In order to complete this program, you will need to have **monthly** appointments with your physician/ dietitian, and a documented treatment plan in your medical records that includes height, weight and discussion/recommendations for diet and exercise plan. You must complete these monthly appointments continuously for the amount of time your insurance policy requires. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement. ***The Mercer Health Weight Management Center can provide forms your physician can use to document these visits.

NUTRITION-RELATED HISTORY

What is your current weight? _____ What is your current height? _____

How many years have you been overweight? _____

Were you overweight as a child? _____

Where is most weight located? Face Abdomen Hips Arms/Legs All

Have you had weight loss surgery or other gastric surgery in the past? Yes No

If yes, please describe: _____

What was your greatest single weight loss in pounds? _____

How did you lose the weight? _____

How long did you sustain that weight loss? _____

Are you currently under a Physician's care for weight loss? Yes No

Physician's Name: _____ Phone: _____

Address: _____

Do you ever make yourself vomit after eating? Yes No

If yes, when was the last time you made yourself vomit after eating? _____

Have you ever used laxatives as a means of weight control? Yes No

Explain: _____

Do you currently have any medical restrictions on your diet? Yes No

If yes, what is restricted and why? _____

Please Check and Provide Information for All That Apply

Medically Supervised Diet Programs:

	No. Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Medi-Fast					
Opti-Fast					
Fen/Phen					
Redux					
Meridia					
Behavior Modification					
Hypnosis					
Dietitian Recommended					

Please Check and Provide Information for All That Apply

Non-MD Supervised Programs:

	No. Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Weight Watchers					
Nutri-Systems					
Jenny Craig					
Other:					

Liquid Diets:

	No. Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Slimfast					
Other:					

Miscellaneous Diets:

	No. Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Low Calorie Diet					
Low Fat Diet					
High Protein/ Low Carb Diet					
Self Imposed Fasts					
Pritikin					
Richard Simmons					
Metabolife					
Herbal Life					
Other:					

Please list ANY other attempts that you have made to lose weight that are not listed:

PSYCHOLOGICAL PROFILE

How long have you been considering bariatric surgery? _____

How did you research the surgery? _____

Have you ever forced yourself to vomit after overeating? Yes No

Have you ever forced yourself to vomit to lose weight? Yes No

If yes, when was the last time you forced yourself to vomit? _____

Do you eat in response to boredom, stress, fatigue, tension, depression, anger, anxiety or loneliness?
 Yes No

Explain: _____

Do you eat because the opportunity is there, even if you are not hungry? Yes No

Explain: _____

Do you eat as a result of negative self-worth? Yes No

Explain: _____

Do you eat in response to physical cues (for example: increased hunger due to skipping meals or eating to cure headache or other pain)? Yes No

Explain: _____

What words best describe what food means to you (check all that apply):

Survival Comfort Energy Love Companionship Calming

Other: _____

Who can you count on to provide you with emotional and physical support while you are in the hospital for surgery and after you go home during the weight loss process: _____

Have you **ever** been treated for psychiatric problems (depression, anxiety, bipolar disorder, schizophrenia)? Yes No

Explain: _____

Have you ever been to the emergency room for psychiatric problems? Yes No

Explain: _____

Have you ever been hospitalized for psychiatric problems? Yes No

Explain: _____

Are you currently seeing a psychiatrist? Yes No

Are you currently seeing a counselor? Yes No

Are you currently taking medications (antidepressants, anti-psychotics, anti-anxiety, mood stabilizers) for psychiatric problems? Yes No

If so please list these medications: _____

Name of the professional prescribing these medications: _____

Do you take more of your medication than prescribed? Yes No

Explain: _____

Do you take illegal drugs (street drugs or medication prescribed for someone else)? Yes No

Explain: _____

Have you ever been a victim of: Sexual abuse Physical abuse Emotional abuse

Other abuse: _____

Please check the following symptoms you are **now** experiencing:

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty in concentrating |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feelings of worthlessness |
| <input type="checkbox"/> Current suicidal thoughts | <input type="checkbox"/> Feelings of helplessness |
| <input type="checkbox"/> Current homicidal thoughts | <input type="checkbox"/> Feelings of being too high or speeded up |
| <input type="checkbox"/> Sleep problems (<input type="checkbox"/> too much, <input type="checkbox"/> too little) | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Loss of energy | <input type="checkbox"/> Hearing voices or seeing things |
| <input type="checkbox"/> Appetite problems (<input type="checkbox"/> too much, <input type="checkbox"/> too little) | <input type="checkbox"/> Feeling physically keyed up |
| <input type="checkbox"/> Guilty thoughts | <input type="checkbox"/> Feeling someone is trying to harm me |
| <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Feeling someone is controlling me |
| | <input type="checkbox"/> Anger or hostility to others |

Please check any of these stressors that are **currently** bothering you:

- | | |
|--|---|
| <input type="checkbox"/> Job | <input type="checkbox"/> Conflicts with: Offspring |
| <input type="checkbox"/> Move | <input type="checkbox"/> Conflicts with: Parents |
| <input type="checkbox"/> Separation or divorce (yours) | <input type="checkbox"/> Conflicts with: Spouse |
| <input type="checkbox"/> Divorce or separation of someone close to you | <input type="checkbox"/> Conflicts with: Neighbors |
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Conflicts with: Co-workers or Boss |
| <input type="checkbox"/> Your physical condition | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Physical condition of a loved one | <input type="checkbox"/> Legal problems |
| | <input type="checkbox"/> Other stressors: _____ |

Do you have ADD/ADHD or any other learning difficulty which requires special instructions for this surgical process? _____

If so please describe what you will need: _____

Behavioral Health Information Form

The following form needs to be filled out by the professional prescribing mental health medications. If you are not taking mental health medications but are seeing a therapist, please have your therapist fill out the form.

Mr./Ms. _____ is currently in treatment with me. The patient's diagnosis is:

Axis I _____

Axis II _____

*Medical Diagnosis: _____

*If the patient is taking a medication specifically for medical reasons, not mental health.

The patient is being treated with the following mental health medication(s): _____

In my opinion, this patient is mentally stable: Yes No

Compliant with treatment: Yes No

And has the cognitive and emotional ability to undergo bariatric surgery and to follow aftercare recommendations: Yes No.

Comments: _____

Signed: _____ Date: _____

Print name: _____ Phone: _____

Address: _____

Please indicate credentials or medical specialty: _____

Please return this completed form by mail or fax to:

Mercer Health Weight Management Center
800 West Main Street
Coldwater, OH 45828

Phone: 419-678-8446
Fax: 419-678-5240