



Emma J Patterson, MD, FRCSC, FACS
Surgeon

825 NE 20th Ave Ste 340
Portland OR, 97232

P: 503.227.5050
F: 503.227.2462

www.oregonwls.com

Thank you for choosing our ASMBS Bariatric Surgery Center of Excellence!

Attached you will find an application which is required to verify your bariatric surgery insurance benefits. This is the first step in determining your path to weight loss surgery. Please allow approximately 6–8 weeks for your application to be fully processed.

If you would like to contact your insurance company directly to determine your insurance benefits, please call the customer service phone number provided on your insurance card. Your insurance company representative may ask you for the below information:

Diagnosis Code:
Morbid obesity – E66.01
Procedure Code:
Sleeve Gastrectomy – 43775
Gastric Bypass – 43644
Lap Band – 43770

Please read this application carefully and provide all information listed. Your completed form may be submitted to our office by fax, mail or email:

Oregon Weight Loss Surgery
825 NE 20th Ave, Ste 340
Portland, OR 97232

503–227–2462 (fax)

info@oregonwls.com (email)

Please use the attached guide for assistance in completing and submitting this application electronically.

Once your application is processed, you will receive a detailed benefits summary via email and you will be ready to schedule a surgical consultation.

Sincerely,

Oregon Weight Loss Surgery, LLC



BARIATRIC SURGERY PATIENT HISTORY

Did you receive our HIPAA Privacy Policies? Yes No

Procedure: Sleeve Gastrectomy Gastric Bypass Lap Band Undecided/Surgery Orbera Balloon

Full Name:			DOB:	Gender:
Address:			Primary Phone:	
City:	State:	Zip Code:	Email:	
Permission to leave detailed messages on your primary phone: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Preferred Language:		Would you like an interpreter in your preferred language? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status:	Spouse Name:		Spouse Phone:	
Permission to discuss care with your spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Emergency Contact:		Relationship:	Phone:	
Permission to discuss care with your emergency contact: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Care Physician:			Phone:	

Insurance Information:

Primary Insurance Name:	
Primary Insurance Address & Telephone:	
Insurance ID:	Insurance Group:
Subscribers Name:	Subscriber's DOB:
Secondary Insurance Name:	
Secondary Insurance Address & Telephone:	
Insurance ID:	Insurance Group:
Subscribers Name:	Subscriber's DOB:
If you are insured as a Legacy Health Systems employee, have you been employed for at least 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you DO NOT have bariatric insurance coverage are you interested in being Cash Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Weight History:

Current Weight:	Current Height:	Most Weight Lost:
Highest Weight:	Lowest Weight:	
Past Dieting Attempts: <input type="checkbox"/> Atkins <input type="checkbox"/> Diet & Exercise <input type="checkbox"/> Jenny Craig <input type="checkbox"/> MD instructed <input type="checkbox"/> Slim Fast <input type="checkbox"/> Weight Watchers		
Other Diets:		

Allergies: Please list any medication allergies you have.

1.	Reaction	2.	Reaction
----	----------	----	----------

Pharmacy:

Preferred Pharmacy:	Phone:
Preferred Pharmacy Address:	

Medications: Please list all prescription, over the counter medications, vitamins and supplements you are taking. Or, attach a comprehensive list.

Name of drug	Mg	Dosage	Frequency	# of years taking this drug

Review of Systems: Have you experienced any of the below symptoms or been diagnosed over the past 12 months?

SYSTEM	YES	SYSTEM	YES	SYSTEM	YES
Gastrointestinal		Mobility		Psychosocial	
Abdominal Hernias		Cane		Anxiety	
Heartburn/GERD		Walker		Depression	
History of Stomach Ulcer		Wheelchair		Genitourinary / Hepatic	
Trouble Swallowing		Cardiac / Neurologic		Kidney Disease	
Respiratory		Congestive Heart Failure		Kidney Stones	
Asthma		History Heart Attack		Leg Swelling	
COPD		Heart Murmur		Liver Disease/NASH	
Obesity Hypoventilation Syndrome		High Blood Pressure		Endocrine / Hematology	
Shortness of Breath		Pseudo Tumor Cerebri		Anemia	
Musculoskeletal		Seizures		Bleeding Disorders/ Clots	
Back Pain/Joint Pain		Stroke		Diabetes	
Chronic Pain, requires opiates		Other		PCOS	
Degenerative Joint Disease		Cancer, Type:		Thyroid Disorder	
Other Medical Conditions:					

Substance Use History

Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Wine per Wk:	Beer per Wk:	Shots per Wk:	Mixed Drink per Wk:
Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Type: <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin			Uses Per Wk:
Tobacco Use: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Other :		
Packs/Day:		Years Used:	Quit Date:	
Smokeless Tobacco Use: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		Type: <input type="checkbox"/> Snuff <input type="checkbox"/> Chew	Quit Date:	

Past Surgical History: Please list all surgeries you have had.

	Year:
Do you have a history of Weight Loss Surgery or Nissen Fundoplication? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History:

Is your father alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your mother alive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cause of death:	Cause of death:
Did he have: <input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Blood Clots	Did she have: <input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Blood Clots

Sleep Concerns History:

Previous Sleep Study Location	Date Performed

Current Sleep Symptoms			
Excessive Daytime Sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Awakenings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-Restorative Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Choking or Gasping During Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current use of CPAP, BiPAP, AutoPAP	<input type="checkbox"/> Yes <input type="checkbox"/> No

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contract to feeling just tired? This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 ----- Would Never Doze 1 ----- Slight Chance of Dozing 2 ----- Moderate Chance of Dozing 3 ----- High Chance of Dozing

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch (without alcohol)	
In a car, while stopped for a few minutes in traffic	



Effective September 1, 2013

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. PURPOSE OF THIS NOTICE.

Oregon Weight Loss Surgery ("OWLS") is committed to preserving the privacy of your health information. In fact, we are required by law to do so for any health information created or received by us. OWLS is required to provide this Notice of Privacy Practices ("Notice") to you. The Notice tells you how we can and cannot use and disclose the health information that you have given to us or that we have learned about you when you were a patient in our system. It also tells you about your rights and our legal duties concerning your health information.

For the rest of this Notice, "OWLS," "we" and "us" will refer to all services, service areas, and workers of OWLS. When we use the words "your health information," we mean any information that you have given us about you and your health, as well as information that we have received while we have taken care of you (including health information provided to OWLS by those outside of OWLS). We will have a copy of the current Notice with an effective date in clinical locations.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AT OWLS.

1. Treatment, Payment and Health Care Operations.

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

- a. For Treatment. We may use your health information to provide you with medical services. We may disclose your health information to staff physicians, post-graduate fellows, physician assistants, nurse practitioners, and other personnel involved in your health care. We may also disclose your health information to students and resident physicians who, as a part of their OWLS educational programs (and while supervised by physicians), are involved in your care. Treatment includes (a) activities performed by nurses, office staff, hospital staff, technicians and other types of health care professionals providing care to you or coordinating or managing your care with third parties, (b) consultations with and between OWLS providers and other health care providers, and (c) activities of non-OWLS providers or other providers covering an OWLS practice by telephone or serving as the on-call provider.

For example, a physician treating you for an infection may need to know if you have other health problems that could complicate your treatment. That provider may use your medical history to decide what treatment is best for you. They may also tell another provider about your condition so that he or she can decide the best treatment for you.

- b. For Payment. We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from OWLS. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment. For example, we may need to give your health plan information about surgery you received at OWLS so your health plan will pay us or reimburse you for the surgery.
- c. For Health Care Operations. We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at OWLS. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective. Or we may give health information to doctors, nurses, technicians, or health profession students for review, analysis and other teaching and learning purposes.

3. Uses and Disclosures You Can Limit

- b. Family and Friends. Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be

circumstances when we can assume, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room during treatment. Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care. For example, we may tell someone who comes with you to the emergency room that you suffered a heart attack and provide updates on your condition. We may also make similar professional judgments about your best interests that allow another person to pick up such things as filled prescriptions, medical supplies and X-rays.

C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. **Required By Law:** As required by federal, state, or local law.
2. **Public Health Activities:** For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, school immunizations under certain circumstances or problems with products.
3. **Victims of Abuse, Neglect or Domestic Violence:** To a government authority authorized by law to receive reports of abuse, neglect or domestic violence when we reasonably believe you are the victim of abuse, neglect or domestic violence and other criteria are met.
4. **Health Oversight Activities:** To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
5. **Lawsuits and Disputes:** In response to a subpoena, discovery request or a court or administrative order, if certain criteria are met.
6. **Law Enforcement:** To a law enforcement official for law enforcement purposes as required by law; in response to a court order, subpoena, warrant, summons or similar process; for identification and location purposes if requested; to respond to a request for information on an actual or suspected crime victim; to report a crime in an emergency; to report a crime on OWLS premises; or to report a death if the death is suspected to be the result of criminal conduct.
7. **Coroners, Medical Examiners and Funeral Directors:** To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.
8. **Organ and Tissue Donation:** To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.
9. **Research:** For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process.
10. **Serious Threat to Health or Safety; Disaster Relief:** To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to notify your family members or persons responsible for you in a disaster relief effort.
11. **Military:** To appropriate domestic or foreign military authority to assure proper execution of a military mission, if required criteria are met.
12. **National Security; Intelligence Activities; Protective Service:** To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
13. **Inmates:** To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that person's custody) as necessary (a) to provide you with health care; (b) to protect your or others' health and safety; or (c) for the safety and security of the correctional institution.
14. **Workers' Compensation:** As necessary to comply with laws relating to workers' compensation or similar work-related injury program.

D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us your specific written authorization to do so. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes that encourage you to purchase a product or service, and for sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, deliver or fax a written revocation to OWLS 1040 NW 22nd Ave, Ste. 500 Portland, OR 97210; fax: (503) 227-5050. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information, which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing to OWLS 1040 NW 22nd Ave, Ste. 500 Portland, OR 97210; fax: (503) 227-5050. In some cases, we may charge you for the costs of providing materials to you.

1. **Right to Inspect and Copy.** With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in our electronic health record, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
2. **Right to Amend.** You have the right to amend your health information maintained by or for OWLS, or used by OWLS to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.
3. **Right to an Accounting of Disclosures.** You have the right to request a list and description of certain disclosures by OWLS of your health information.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service for which OWLS has been paid out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a surgery you had, a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in 4(c) above, we are not required to agree to your request. Any time OWLS agrees to such a restriction, it must be in writing and signed by the OWLS Privacy Officer or his or her designee.
5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain place. OWLS will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.
6. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice.
7. **Right to be Notified of a Breach.** You have the right to be notified if there is a breach – a compromise to the security or privacy of your health information – due to your health information being unsecured. OWLS is required to notify you within 60 days of discovery of a breach.

F. REVISIONS TO THIS NOTICE

We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. OWLS will post the revised Notice at OWLS clinical locations and provide you a copy of the revised notice upon your request.

G. QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact OWLS (503) 227-5050. If you believe your privacy rights have been violated, you may file a complaint with OWLS or with the Secretary of the Department of Health and Human Services. To file a complaint with OWLS, contact OWLS at (503) 227-5050. You will not be penalized for filing a complaint. This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.

Application Submission Guide

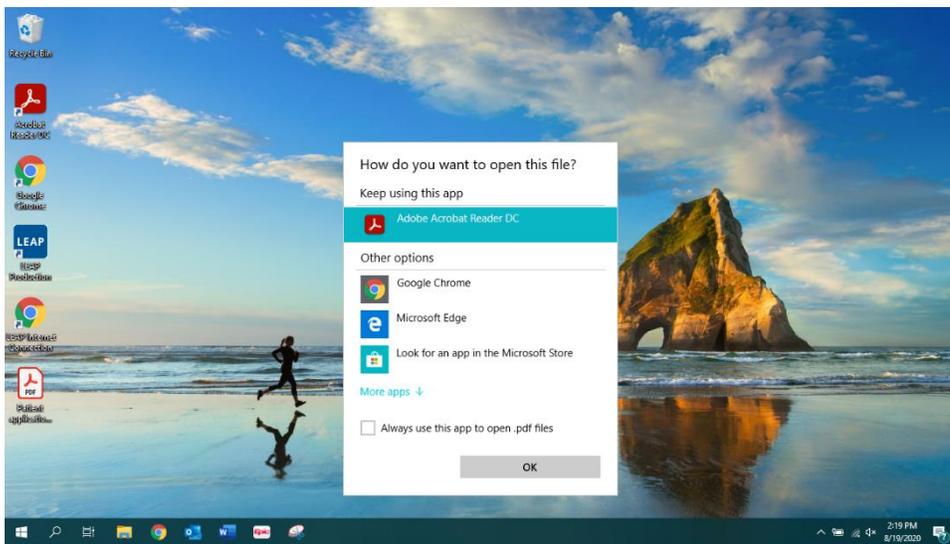
A quick guide on how to submit your completed application

The following guide will detail how to fill out, save and return your application for our program. It has been broken up into sections for different devices, including computer and mobile devices. This is meant to help answer basic questions and the most common issues that people encounter when filling out and returning their applications. You may also call the office at (503) 227-5050 with any further questions, or for additional assistance. Please contact our office if you would like a paper copy of the application mail to you, if filling it out digitally is not possible.

Windows 10 Instructions

Opening and Filling Out your Application

- Make sure that you have a PDF reader application on your computer. Adobe Reader is a free computer application. You can download this app by clicking [here](#).
- Open the application using Adobe Reader. You may see a selection like this:



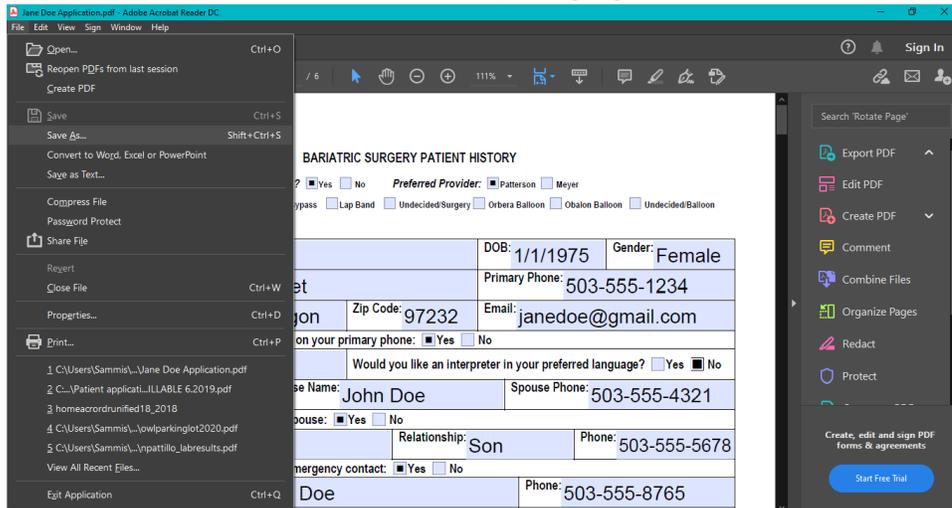
Make sure to select Adobe Reader for this. If you are first downloading Adobe Reader, your default program for PDF viewing may be set automatically to your default internet browser.

- Once you have the application open in Adobe Reader, you will be able to fill out the form directly in that program.
- Make sure that when you fill out the application, you fill out the application to the fullest extent – the more detail you provide to us, the more accurately we will be able to determine your presurgical requirements and your insurance benefits.

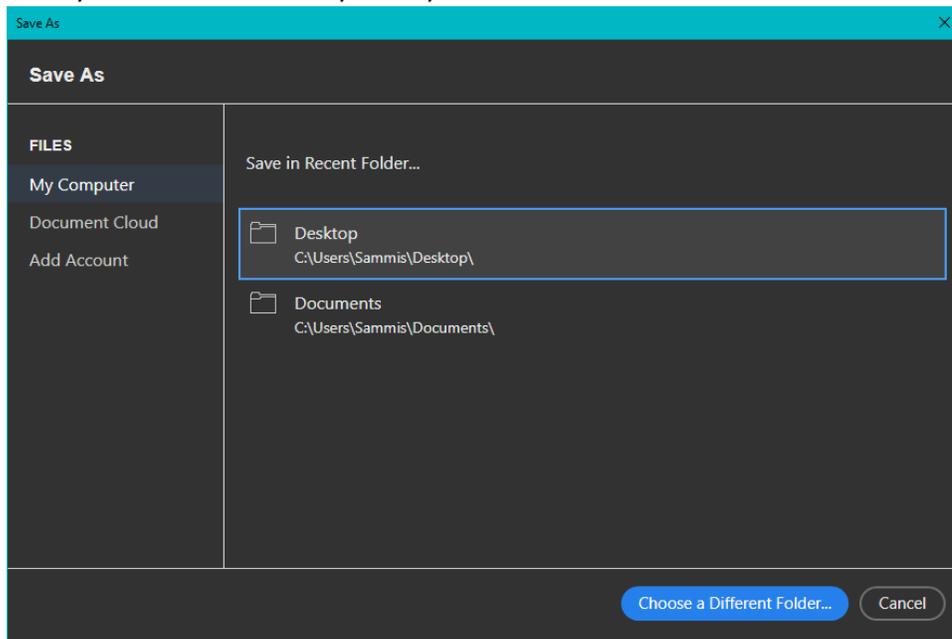
Saving the Application – “Save As”

- Once you fill out the application, you will need to save it to send the completed application to us. A common error that delays our process is sometimes a patient will accidentally send back their application blank. To avoid this, be sure to save the completed application like this.

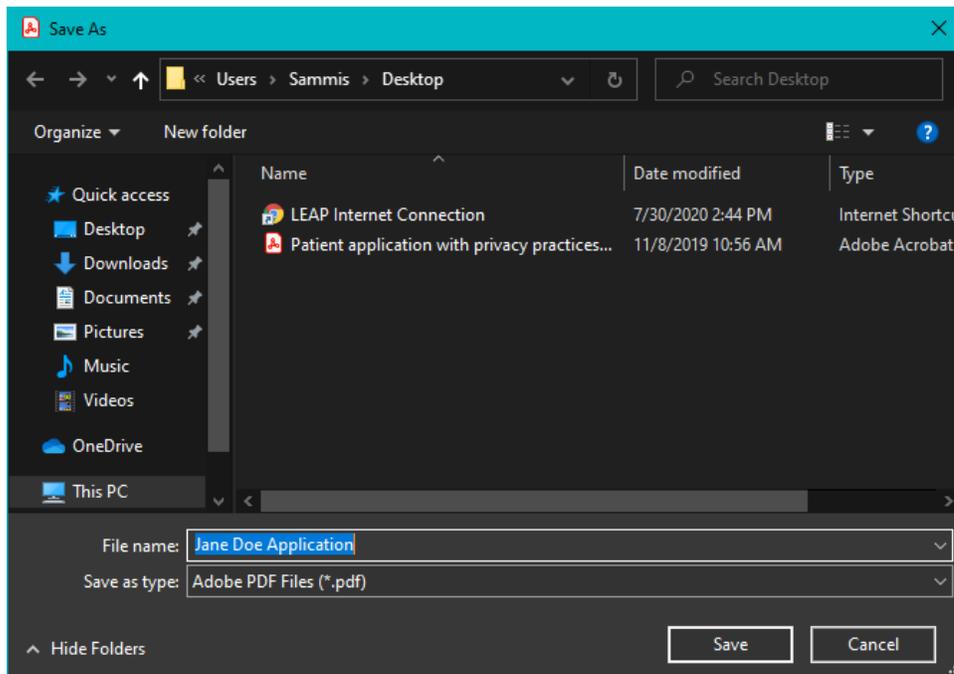
- Click on “File” and then click on “Save As”, as highlighted below:



- Once you click on “save as” you may see this screen:



Click on “Desktop” here as highlighted above,

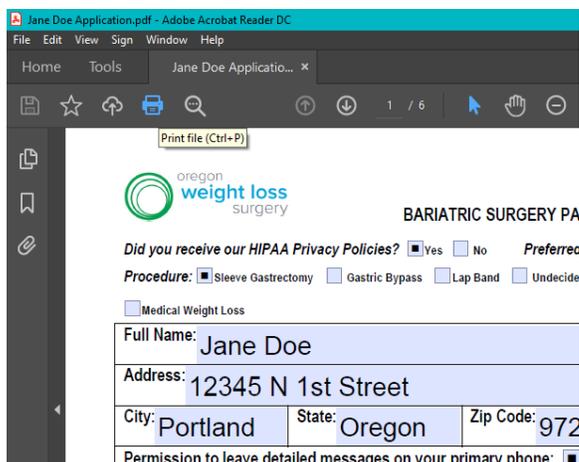


Make sure to change the name of the file to something recognizable from the original (blank) PDF. Your name is a good option. Also make sure to keep the file type stays as a .pdf.

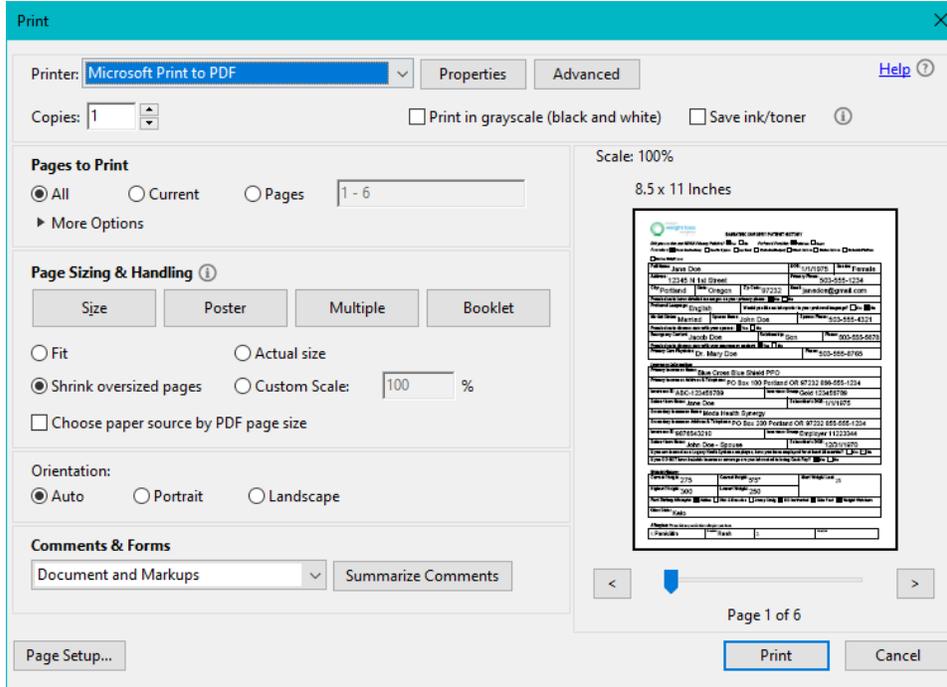
- Click “save”. The completed application will now be on your desktop. You will now be able to attach this completed application to an email for submission.
- If you are unable to use the “save as” function, skip to the next section.

Saving the application – Print to PDF

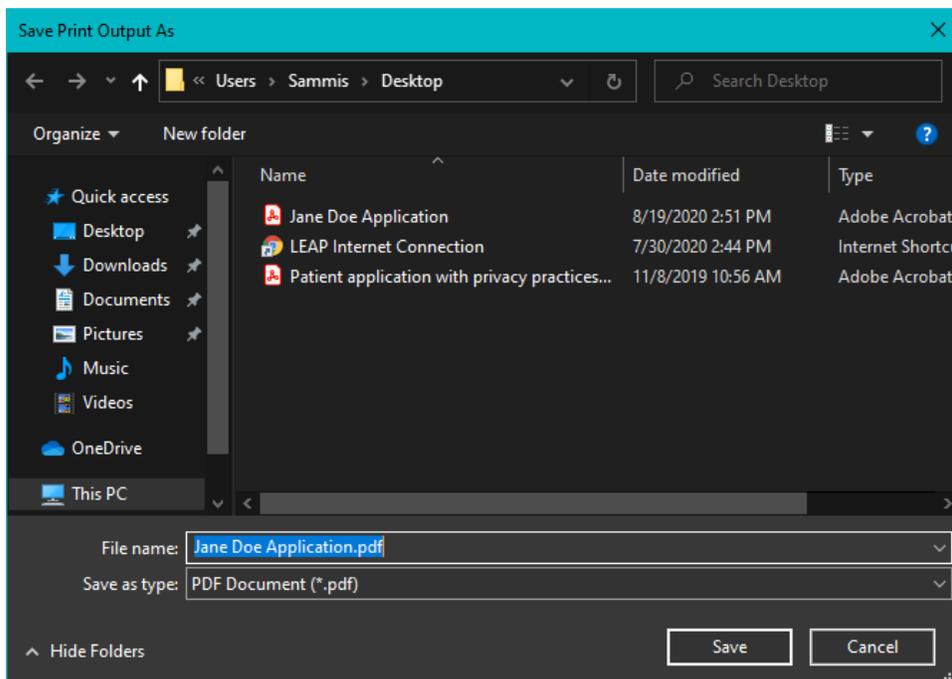
- Sometimes, for whatever reason, you may be unable to use the “save as” function. To work around this, you can use a function called “Print to PDF”. This will essentially “print” the document, but instead of printing it on paper, your computer will make a copy of the completed document.
- To use this function, click on the “Print” button, highlighted in blue:



- From there, select “Microsoft Print to PDF” from the printer selection drop down menu as highlighted below then select “Print” at the bottom of the window:



- After that, the same window as the previous section will come up allowing you to change the document name, saving location, and file type. Using a recognizable name, such as your name, location, such as your computer’s desktop, and file type of .pdf are strongly recommended.



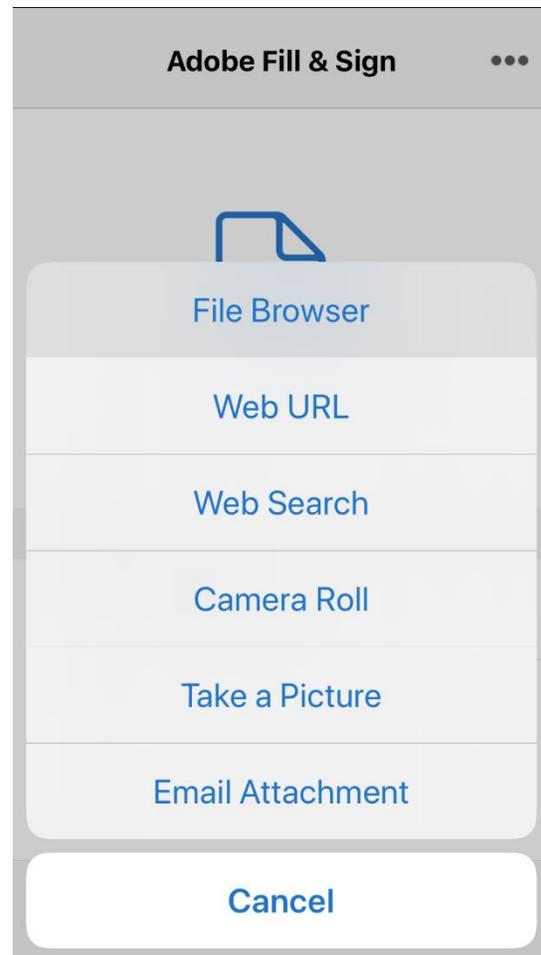
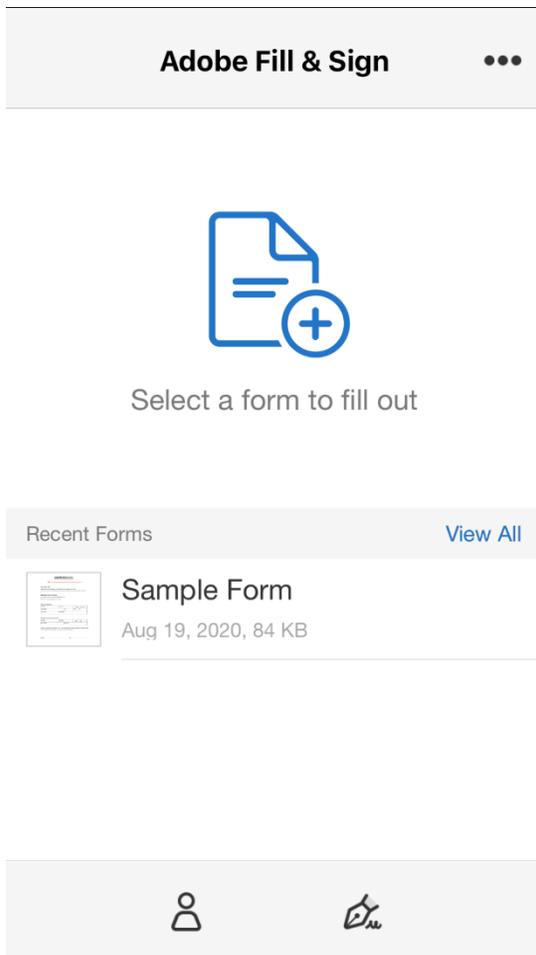
iPhone/iPad

Opening and Filling out your application

- Once you finish the seminar, to download the application to your phone you will want to save it to your “Files” app that comes with the current Apple operating system. This will allow you to open it in your PDF filler app. Adobe Fill & Sign is a free app that allows you to fill out the application on your phone. It can be found in the Apple App Store, or by clicking [here](#). Pictured below are the Files and Adobe Fill & Sign apps.



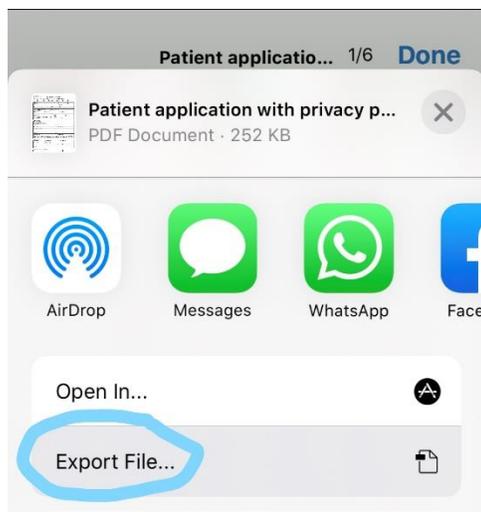
- To open the application in Fill & Sign, choose the “Select a form to fill out” button and then choose the “File browser” option:



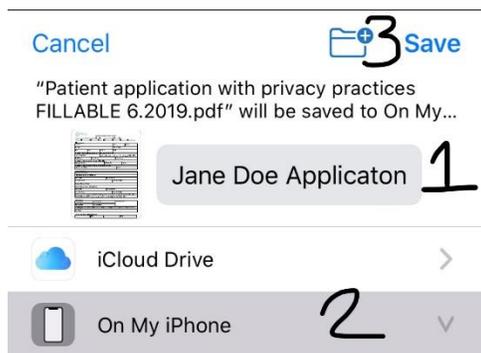
- If it is your first time using Fill & Sign, it will run through a tutorial on how to use the functions of the app. Follow those instructions to fill out the application to the fullest extent and make sure to include all of your insurance information and medical history in the provided boxes.
 - Fill & Sign has a “Profile” function which will save your demographic information and auto-fill in the appropriate boxes if you wish to use it for our applications and any future PDFs you may need to fill out, although it is not required.

Saving and Submitting your application

- Once you have filled out the application, to save it back to your Files you will need to select the “Share” button at the bottom right corner of the app. It looks like a square with an arrow pointing up. From there, select “Export File...” from the selection menu, highlighted below in blue:



After you select that, the following menu will appear:



1. First, you will need to click on the document name to change it to something recognizable (marked “1” on the picture). This will help you to differentiate it between your completed form and the blank form in your Files.
2. Second, you will need to select where to save the document. Choosing “On My iPhone” will save it to your files (marked “2” on the picture) will save it to your Files app.
3. Last, click the “save” button on the top right-hand corner (marked “3” on the picture).

Attaching to an email

- This will vary between email providers exactly where the buttons are located, but the steps are basically the same between them. This tutorial will cover Mail, Apple's integrated email service, but the steps can be easily translated to other email services such as Gmail and Yahoo.
- To attach your completed application to an email for submission, first start a new email by clicking on the bottom right button in the app, it looks like a square with a pencil.
- Address the email to info@oregonwls.com
- In the subject line, write "Application"
- To attach your application, select the document button highlighted below in yellow, and then your completed application from your files in the "on my iPhone" folder (which will open by default)

