Platinum Surgical Care

Gregg A. Ginsburg, M.D., F.A.C.S.

1455 Highway 61, Suite B, Festus, MO 63028
13303 Tesson Ferry Rd., Suite 150, St. Louis, MO 63128
5034 Griffin Rd., St. Louis, MO 63128
507 West Pine St., Farmington, MO 63640
Phone 636-931-4744 or Toll free 877-931-4744
Fax 636-931-4739

Thank you for considering Platinum Surgical Care to help you take control of obesity in your life. For people suffering from severe obesity and related health conditions, weight-loss surgery may be the solution they have been searching for. For best results, patients need to actively participate in a multi-disciplinary weight-loss program which includes nutritional, emotional, and exercise counseling. We are committed to providing the highest level of patient care every step of the way. Dr. Ginsburg is board certified and holds active membership with the American College of Surgeons. We will make every effort to assist you in obtaining approval from your insurance company but your participation in this often lengthy process is essential.

You are scheduled for an appointment with Dr. Ginsburg on:

We ask that you arrive at least 15 minutes prior to your scheduled appointment.

You will be seen at the following location:

- ***1455 Highway 61, Suite B, Festus, MO 63028***
- ***13303 Tesson Ferry Road, Suite 150, St. Louis, MO 63128***
- ***5034 Griffin Road, St. Louis, MO 63128***
- ***507 West Pine Street, Farmington, MO 63640***

Please complete the enclosed forms and bring them with you to your appointment. The information you provide must be complete as it is used by our office to aid in the precertification process. You will also need the following:

- ***Your insurance card***
- ***A referral if required by the insurance company***
- ***Bring a list of your medications***

Please visit our website at www.platinumsurgicalcare.com

PLATINUM SURGICAL CARE
Gregg A. Ginsburg, MD, F.A.C.S.

Name: ______________________ **Date of Birth:** __________ **Sex:** M F

Address: ______________________ **City:** __________ **State**: __________ **Zip:** __________

Home Phone: ______________________ **Cell Phone:** ______________________

Employer: ______________________ **Employer Phone:** ______________________

Social Security # ______________________ **Marital Status:** ______________________

E-Mail Address: ______________________

Name of Emergency Contact: ______________________ **Relationship:** ______________________

Phone Number: __________ **Address of Emergency Contact:** ______________________

Primary Care Doctor: ______________________ **Referring Doctor:** ______________________

Primary Insurance: ______________________ **ID Number:** ______________________

Cardholder's name: ______________________ **Cardholder's SSN:** ______________________

Relationship to Patient: ______________________ **Cardholder's date of birth:** ______________________

Cardholder's Employer: ______________________

Secondary Insurance: ______________________ **ID Number:** ______________________

Cardholder's name: ______________________ **Cardholder's SSN:** ______________________

Relationship to Patient: ______________________ **Cardholder's date of birth:** ______________________

Cardholder's Employer: ______________________

I hereby authorize my insurance benefits, including Medicare & Medicaid, to be paid directly to Gregg A. Ginsburg, MD. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges, whether or not paid by said insurance. I also understand that failure to provide the proper insurance information or obtain any required insurance plan referrals will result in my acceptance of full financial responsibility for these services.** I hereby authorize said assignee to release all information necessary to secure that payment. In the event this account is assigned to collections, I agree to pay all cost of collection including reasonable attorney fees. It is the policy of Platinum Surgical Care to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be denied the benefits of any service, or to be subject to discrimination because of race, color, national origin, religion, sex, age or disability. If you believe you have been denied a benefit of service because of your race, color, national origin, religion, sex, age or disability, you may file a Complaint of Discrimination with our office, either verbally or in writing

Signature of Patient or Parent/Guardian ______________________ **Date:** __________

If my insurance plan(s) excludes bariatric benefits, I understand that no insurance claim will be submitted to my insurance carrier(s). Fees associated with office visits and procedures for the treatment of obesity will be my financial responsibility. Charges for services rendered for the treatment of obesity will be collected at the time of service. I understand that my appointment will be rescheduled if I am unable to issue payment at the time of service. Photos are taken by our office as part of your medical record. I understand that my photos would only be shared with physicians who provide me care and a separate photo release would be required before my photos would be available for anyone else to view.

Signature of Patient or Parent/Guardian ______________________ **Date:** __________

Patient Name:____**Date of Birth:**_________________

MEDICATION NAME	**DOSAGE**	**MEDICATION NAME**	**DOSAGE**

ANY MEDICATION ALLERGIES? **Yes** **No** If yes, be specific______________________________________

MEDICAL HISTORY, REASON FOR MEDICATIONS

____
____
____
____

PLEASE LIST ANY PREVIOUS SURGERIES, SERIOUS INJURIES, HOSPITALIZATIONS

____
____
____
____

PATIENT SOCIAL HISTORY:

Alcohol use? Never Rarely Moderately Daily
Recreational Drug Use? No Yes
Tobacco Use? No Yes Packs per Day____ Do you smoke: ___ everyday ___ some days, but not everyday
Are you a: ___ Current Smoker ___ Former Smoker ___ Never a Smoker Are you interested in quitting? ___ Yes ___ No
Caffeine Consumption:

OCCUPATION

Are you currently employed? Yes No

If employed, please circle what level of activity your job involves: Little, sedentary job Moderately Active Very Active (Laboring)

FAMILY MEDICAL HISTORY

	Age	Please list diseases and health history	If deceased, cause of death
Father:	_____		
Mother:	_____		
Siblings:	_____		
Children:	_____		

Authorization to Access Rx History Information: I hereby authorize Platinum Surgical Care to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

Patient Name _______________________________________ **Signature**____ **Date** ___________

Preferred Pharmacy ____ Phone Number ___________________________________

Location or Address of Pharmacy ____

Mail Order Pharmacy ____ Location _____________________________________

The following information is now being required for Government Reporting purposes. Please complete ALL sections.

Race: White Black or African American Hispanic American Indian or Alaskan Native Asian Other __________

Language: English Spanish Indian Other ___________________

Ethnicity: Non-Hispanic Hispanic Other ____________________

Patient Name:____**Date of Birth:**_________________

***CONSTITUTIONAL SYMPTOMS**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

***EYES**

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

***EARS*NOSE*THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

***CARDIOVASCULAR**

Heart disease	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Hypertension	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	Yes

***RESPIRATORY**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

***GASTROINTESTINAL**

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea or vomiting	No	Yes
Rectal Bleeding or blood in stool	No	Yes
Abdominal Pain	No	Yes

***BREAST**

Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

***NEUROLOGICAL**

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling sensation	No	Yes
Stroke	No	Yes
Head injury	No	Yes

***ENDOCRINE**

Glandular/Hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes

***HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged Glands	No	Yes

***GENITOURINARY**

Frequent urination	No	Yes
Burning/painful urination	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes

How did you hear about us?

Physician referral	____	TV Commercial	____
Friend	____	Radio Station	____
Newpaper Ad	____	Other	____

Patient Name:____**Date of Birth:**_________________

WEIGHT HISTORY

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

	Below Average	Average	Above Average	Very Heavy
Birth Weight				
Weight at age 5-10 years				
Weight at age 10-12 years				
Weight at age 15-18 years				
Weight at age 20-29 years				
Weight at age 30-60 years				

Your current Weight: ___________________ **Height:** ________________

WEIGHT LOSS HISTORY

Please list all weight loss programs in the past FIVE years you have done

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Jenny Craig				
Liquid Diets				
Metabolife				
Nutri-System				
Optifast				
Others				

Details of previous weight loss surgery:____ None_____

MEDICATIONS

Have you taken medications to assist with weight loss? Yes No

If so, please list them and how long you took them

Medication Name	How long you took them	Any weight loss
______________________________	______________________________	___________________
______________________________	______________________________	___________________
______________________________	______________________________	___________________
______________________________	______________________________	___________________
______________________________	______________________________	___________________

Patient Name:____**Date of Birth:**_________________

Non-dietary therapy

Accupuncture?	No	Yes	Details: ______________________________
Exercise?	No	Yes	Details: ______________________________
Hypnosis?	No	Yes	Details: ______________________________
Behavior Modification?	No	Yes	Details: ______________________________

Sleep History

Do you snore? Yes No

How many hours of sleep do you get a night? _______________

Would you consider the quality of your sleep as: Good Fair Poor

Do you wake during the night with a choking feeling?	Never	Sometimes	Always
How often do you wake up, more than once during the night?	Never	Sometimes	Always
Do you have a headache when you wake up in the morning?	Never	Sometimes	Always
Have you noticed a reduction in your libido or sex drive?	Never	Sometimes	Always
Do you feel sleepy during the day?	Never	Sometimes	Always
Do you feel sleepy in the evenings?	Never	Sometimes	Always
Has anyone noticed that you momentarily stop breathing during your sleep?	Never	Sometimes	Always
Do you fall asleep while reading?	Never	Sometimes	Always
Do you wake up in the morning feeling confused?	Never	Sometimes	Always
How often do you have a nap during the day?	Never	Sometimes	Always
Have you or anyone else noticed a change in your personality recently?	Never	Sometimes	Always
How often do you doze off or fall asleep while driving?	Never	Sometimes	Always

Gastroesophageal Reflux/Indigestion

Do you have heartburn or indigestions?	Yes	No	
Do you suffer from indigestion at night?	Always	Sometimes	Never
Do you have difficulty swallowing?	Yes	No	
Do you have problems with food getting stuck?	Yes	No	
Do foods or fluids reflux into your mouth?	Yes	No	
Do you have vomiting associated with reflux?	Yes	No	
Do you have a hoarse voice?	Yes	No	
Do you have recurrent sore throats?	Yes	No	
Do you have a regular cough at night?	Yes	No	

Breathing History

Have you had prior exposure to gas, vapors, or dust?	Yes	No		
Do you have asthma?	Yes	No		
Do you have shortness of breath with exertion?		Always	Sometimes	Never
Do you have shortness of breath with walking on flat surfaces?		Always	Sometimes	Never
Do you have shortness of breath with walking up hill?		Always	Sometimes	Never
Do you have wheezing in your chest?		Always	Sometimes	Never
Do you have wheezing that came on after exercise?		Always	Sometimes	Never
Do you have tightness in your chest upon waking in the morning?		Always	Sometimes	Never

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Fax number (636)931-4739

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name ____________________________________

Relationship to Patient ____________________________________

Signature ____________________________________

Date ____________________________________

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If so, please list names below for our record.

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Do you authorize our office to call your home and leave a message about test results or other information on your answering machine? YES NO I don't have a machine

Do you authorize our office to call you at work? YES NO NA

Comments: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: ____

Staff Initials: ______________________ Date: _______________________

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This form will be used to obtain or release medical records when required for treatment or medical care for the below named patient. Please sign and date.

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name________________________________ Date of Birth ________________________

I hereby authorize ______________________________to obtain or release protected health information for the purposes described below.

Description of the specific information to be obtained or released: __________________

____

The persons in our workforce authorized to make the disclosure is: Medical Records Dept.

The person or entity to whom we will disclose the information, and who may use it are:

____.

The purpose for which the use/disclosed information will be used:
____.

- You may refuse to sign this authorization. Your refusal will NOT affect your ability to obtain treatment, payment or eligibility for benefits.
- If the persons who are authorized to receive the information above are NOT health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect it.
- You may inspect or copy the protected health information to be used or disclosed under this authorization. Please send your request to the above address.
- Once you give us this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our office at the above location. However, your revocation will not prohibit us from

a. any acts we have already taken in reliance of the authorization, or

b. any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage. If not revoked, this authorization will expire one year from the date of the signature below.

X____________________________________ Date:______________________

Signature (Patient or Legal Representative)

Capacity of Legal Rep.______________________________

NOTICE OF PRIVACY PRACTICES
For
Platinum Surgical Care

Gregg A. Ginsburg, M.D., F.A.C.S

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.

The Health and Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include a physical exam.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of the notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

U.S. Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
Toll free 1-877-696-6775