RMAP Patient Information Form *(Please Fill Out Completely)*

☐ Steven Simper MD, FACS ☐ Rodrick McKinlay MD, FACS ☐ Nicholas Paulk, MD, FACS ☐ Douglas Greer, MD

Please check one: ☐Self Pay ☐ Insurance Pay

Procedure: ☐ **Gastric Bypass** ☐ **Sleeve** ☐ **Duodenal Switch** ☐ **Revision** **Other**_____

Name (First) (Middle) (Last)			*Date of Birth*	*Sex*	*Marital Status*
Address			*Primary Phone (include area code)* ( )		*Secondary Phone (area code)* ( )
City	*State*	*Zip*	*Patient Email*		*Social Security #*
Occupation	*Employer*				*Your Ethnicity*
Employment Address			*Work Phone (include area code)* ( )		

Primary Insurance Holder Information

Name (First) (Middle) (Last)			*Date of Birth*	*Relationship to Patient*	
Address	*City*	*State*		*Zip Code*	*Phone (include area code)* ( )
Employer	*Employment Address*				*Phone(include area code)* ( )
Primary Care Physician	*Address*			*Phone (including area code)* ( )	
Referring Physician	*Address*			*Phone (including area code)* ( )	

Emergency Contact (First) (Last)	*Relationship*	*Phone (include area code)* ( )	
Address	*City*	*State*	*Zip*

How did you hear about our clinic?

☐ *Physician*	☐ *Internet*	☐ *Radio*	☐ *TV*	☐ *Facebook*	☐ *Pinterest*	☐ *Other*
☐ *Hospital*	☐ *Patient/Friend*	☐ *Billboard*	☐ *Work*	☐ *Insurance Company*	☐ *Yellow Pages*	

PRIMARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

SECONDARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) may be added when my account becomes 90 days past due. I understand that I may receive text messages or emails relating to my account. If it becomes necessary for my account to be turned over to a collection agency, I understand that an additional collection fee of up to 40% may be added to my balance. I understand I will be responsible to pay all collection fees, attorney fees and court costs. Confidential Record: Information contained here will not be released except when you have authorized us to do so. Note: This form will be submitted to your insurance company with the letter of medical necessity and your medical records. I am also aware that there will be a $25 charge should I be considered a frequent "no show", or continually rescheduling my appointments.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: **Steven C. Simper M.D., Rodrick D. McKinlay M.D., Nicholas J. Paulk M.D., or Douglas C. Greer M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company and immediate family.

Signed _____ Date:_____ Date Revised or Updated: _____

Patient/ Responsible Party

Rocky Mountain Associated Physicians
Specializing in Weight Loss Surgery since 1979

MEDICAL HISTORY

Date: _____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Reason for Visit: _____

_____

Surgeon Selected:
- ☐ Dr. Simper
- ☐ Dr. McKinlay
- ☐ Dr. Paulk
- ☐ Dr. Greer

Past Medical History: Check all that apply

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clots (DVT/PE)
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Chronic Kidney Disease
- ☐ Colon Cancer
- ☐ Congestive Heart Failure
- ☐ COPD (Lung Disease)
- ☐ Coronary Artery Disease (CAD)
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ GERD (reflux)
- ☐ HIV/AIDS
- ☐ Heart Attack (MI)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stones
- ☐ Liver Disease/Cirrhosis/Hepatitis
- ☐ Obesity
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Pre-Diabetes
- ☐ Problems with Anesthesia
- ☐ Prostate Cancer
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Smoker/Vape
- ☐ Stroke
- ☐ Thyroid Disease/Hypothyroidism
- ☐ Ulcerative Colitis
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Past Surgical History:

Weight Loss Surgeries: ☐ **None**

Type of Surgery	Year	Hospital

Other Surgeries: ☐ **None**

Type of Surgery	Year

Type of Surgery	Year

Hospitalizations (reason and approx. year)

_____ _____

_____ _____

Allergies: Medications ☐ None

_____

_____

Allergies: Other ☐ None

_____

_____

Rocky Mountain Associated Physicians
Specializing in Weight Loss Surgery since 1979

Current Healthcare Providers:

	Name	Address	Phone Number
Cardiologist			
Endocrinologist			
Gastroenterologist			
Hematologist/Oncologist			
Mental Health Provider			
Primary Care Provider			
Pulmonologist			
Other:			

Current Medications: ☐ Currently not taking medications

Name of Medication:	Dose:	Frequency:	Condition:

Family History: Have any of your family members had the following? give relationship

Stroke:	Cancer:
High Blood Pressure:	Tuberculosis:
Diabetes:	Bleeding Tendency:
Heart Attack:	Deep Vein Thrombosis (DVT):
Pulmonary Embolism:	Problems with Anesthesia:

Details regarding the above if any:

_____

_____

Rocky Mountain Associated Physicians
Specializing in Weight Loss Surgery since 1979

Family Medical History

	Age	Health Challenges (If Any) Indicate of Obese (100lbs + overweight)	If deceased – Cause	Age
Father				
Mother				
Brothers				
Sisters				
Husband/Wife				
Sons				
Daughters				

REVIEW OF SYSTEMS

CARDIOVASCULAR

	Yes	No
High Blood Pressure		
Taking medication?		
Congestive Heart Failure		
Ischemic Heart Disease		
Heart stress test		
Previous Heart attack		
Stents placed in Heart?		
Heart surgery?		
Heart catheterization		
Pacemaker or Defibrillator?		
Angina chest pain		
Peripheral Vascular Disease		
Stroke		
Lower Leg Edema / Swelling		
Blood clot in leg or lung		
Taking a blood thinner?		
Vena Cava heart filter		

METABOLIC

	Yes	No
Diabetes Mellitus, Type 1		
Diabetes Mellitus, Type 2		
Fasting Glucose > 99 mg/dL		
Oral medication for Diabetes		
Insulin use		
Eye / Kidney problems		
High Cholesterol or Lipids		
Taking medication		
Gout / High Uric Acid levels		
Thyroid issues		

PULMONARY

	Yes	No
Previous Sleep Study		
Sleep Apnea		
CPAP/BIPAP		
Oxygen use at home		
Pulmonary Hypertension		
Asthma		
Inhaler use due to asthma		

Rocky Mountain
Associated Physicians
Specializing in Weight Loss Surgery since 1979

GASTROINTESTINAL

	Yes	No
Heartburn / Reflux / GERD		
Heartburn medication use		
Past anti-reflux/hiatal hernia surgery		
Past Gastric Ulcers		
Barrett's Esophagus		
Crohn's Disease or Colitis		
Gallstones		
Gallbladder removed		
Abnormal liver tests		
Fatty liver disease		

GENITOURINARY

	Yes	No
Kidney Disease		
Currently on or ever required dialysis?		
Kidney Stones		
Trouble with urination		
Blood in urine		
Urinary incontinence		

MUSCULOSKELETAL

	Yes	No
Back Pain		
requiring medication		
Hip / Knee / Ankle pain		
requiring medication		
Degenerative Joint Disease		
Osteoarthritis		
Fibromyalgia		
Joint replacement		
Back surgery		

REPRODUCTIVE (female)

	Yes	No
Polycystic Ovarian Syndrome		
Infertility		
Menstrual irregularities		
Hysterectomy		

GENERAL

	Yes	No
Pseudo tumor Cerebra		
Abdominal hernia		
Hernia repair		
Cane / Walker use		
Sores / rash in skin folds		
MRSA		
VRE		
Lupus/ Autoimmune disease		

PSYCHOLOGICAL

	Yes	No
Anxiety/Panic Disorder		
Depression		
Bipolar disease		
Thoughts of suicide		
Suicide attempts		
Psychiatric treatment		
Psychological counseling		
Hospitalized for psychological issue(s)		

PERSONAL HABITS

	None	Rare	Occasional	Frequent
Alcohol Use				
Substance Abuse				
Tobacco Use				
How many years?				
Quit? If so, when?				

Rocky Mountain Associated Physicians
Specializing in Weight Loss Surgery since 1979

WEIGHT MANAGEMENT HISTORY

This form is submitted to your insurance company with your letter of medical necessity. Approval or denial of your request for surgery depends on meeting the criteria put forth by your insurance company. Failure of multiple attempted dietary programs is a standard requirement. Also required for Self-Pay Patients

Please fill out in detail.

Please Indicate Approximate Weights – How many years have you been morbidly obese? _____

(Mark the category with an X for each age range listed)

		Normal	Obese	Morbidly obese (100 pounds over ideal weight)
Childhood	1-10 years			
Adolescence	11-18 years			
Young Adult	18-30 years			
Adult	30-60 years			

Number of visits yearly to your physician for medical problems (asthma, hypertension, heart problems, joints, arthritis, respiratory, circulation, etc.) related to obesity. _____

Doctors who are following, or have followed, your weight problems: NAME	Diet programs your doctor has you trying, or has had you try:	Weight Lost	Weight Regained	Length Of Program	Estimated Cost

How long have you been considering weight loss surgery?			
	Yes	No	Comment
Have you ever forced yourself to vomit after overeating?			
Have you forced yourself to vomit to lose weight?			
Do you eat in response to boredom, stress, fatigue, tension, depression, anger, anxiety or loneliness?			
Do you eat when the opportunity is there, even when you aren't hungry?			
Do you eat as a response to negative self-worth?			
Do you eat in response to physical cues? (hunger, headache, other pain)			
What words describe what food means to you?	Mark all that apply		
Survival			
Comfort			
Energy			
Love/Companionship			
Calming			
Other			

Rocky Mountain
Associated Physicians
Specializing in Weight Loss Surgery since 1979

PROGRAM	YEAR	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
WEIGHT WATCHERS					
TOPS					
OVEREATERS ANONYMOUS					
DIET CENTERS					
Jenny Craig					
Nutri-System					
MD Diet					
LA Weight Loss					
BEHAVIOR MODIFICATION					
APPETITE SUPPRESSANT PILLS					
Weight Loss Medication					
SHOTS					
HYPNOSIS					
HOODIA					
SET FOR LIFE					
HERBAL LIFE					
SLIM FAST					
AMERICAN HEART ASSOCIATION DIET					
SLIM FOR LIFE					
RICHARD SIMMONS					
ACUPUNCTURE					
FAD DIETS					
SELF IMPOSED DIET ATTEMPTS					
OTHER					
OTHER					

Physical Exercise - Last 5 years (what was your normal routine?)

Do you have physical limitations that make physical exercise difficult or impossible? ☐ Yes ☐ No

Please Describe: _____

PROGRAM	TIME SPENT per Week	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
Bicycling					
Jogging / Walking					
Swimming					
Spa / Gym					
Aerobic/Video tapes					
Health Rider					
Home gym equip.					
Curves					
Other					
Other					

Rocky Mountain
Associated Physicians
Specializing in Weight Loss Surgery since 1979

Describe the limitations (physical, emotional, employment) morbid obesity imposes on you in your daily activity: (Please describe in detail)

Rocky Mountain Associated Physicians, P.C.
NOTICE OF PRIVACY PRACTICES
Effective: June 30, 2013

Patient Name: _____ **Date:** _____

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

Privacy Policy
We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How We Use Your Health Information
When you receive care from Rocky Mountain Associated Physicians, P.C. we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information include:

Treatment – We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. Some health records, including some confidential communications with a mental health professional and some substance abuse records, may have additional restrictions on the use and disclosure under state and federal laws.

Payment – We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company or Medicare.

In order for us, or for any other person or entity who provides goods or services to you in connection with this agreement, to contact you regarding servicing your account(s), including all past and current accounts, or to collect any amounts you may owe for any past or current account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection. I/We have read this disclosure and agree that I/we may be contacted as described above.

Health Care Operations – We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

Other Uses of Your Health Information
We may also use your health information to:

- Recommend treatment alternatives.
- Tell you about health services and products that may benefit you.

- Share information with family or friends involved in your care or payment for your care, when appropriate.
- Share information with third parties who assist us with treatment, payment, and health care operations. We require our business associates to appropriately safeguard your information in accordance with law.
- Remind you of an appointment.
- Contact you or provide you with our education materials such as newsletters or research participation requests.

More Information
For more information about the practices and rights described in this notice contact our office manager at the phone number and address at the bottom of this notice.

Sharing Your Health Information
There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations are:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For law enforcement purposes.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- For organ and tissue donation.
- For research under strict federal guidelines.
- To reduce or prevent a serious threat to public health and safety.
- For workers' compensation or other similar programs if you are injured at work.
- For accreditation purposes; and
- For specialized government functions such as intelligence and national security.

We may also submit your personal health information to the Medicaid eligibility database, the Children's Health Insurance Program eligibility database, and/or other shared clinical databases or health information exchanges. All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement (with limited exceptions as provided by federal regulations).

Your Individual Rights
You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- * Request to inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information, and you may request a review of the denial.
- * Request corrections or additions to your health information.
- * Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free, but a fee will apply if more than one request is made in a 12-month period: and
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the Rocky Mountain Associated Physicians office manager for the appropriate form for your request.

Our Privacy Responsibilities

Rocky Mountain Associated Physicians is required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your health information.
- Accommodate reasonable requests to communicate your health information by alternative means or at alternative locations.
- Notify you of any reportable breaches of your unsecured health information; and
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in our facilities and on our website, www.RMAP.com. You may also request a copy of any notice from our office manager.

Our Organization

This notice describes the privacy practices of Rocky Mountain Associated Physicians, P.C., Rocky Mountain Associated Physicians, P.C. includes physicians, employees and volunteers. This notice also describes the privacy practices of affiliated providers while they are performing services on behalf of Rocky Mountain Associated Physicians unless they provide you with a notice of their specific privacy practices. Affiliated providers are not employed by Rocky Mountain Associated Physicians but are authorized to provide services to patients. Affiliated providers may have different privacy practices from those described in this notice. For more information about the privacy practices of affiliated providers, please contact them directly.

Contact Us

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, contact: Rocky Mountain Associated Physician's office manager at 801-268-3800.

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

I have read and understand this Privacy Notice:

I give permission for the following family members or friends to be contacted regarding my medical care (List Name and Telephone):

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature: _____

RMAP Witness: _____

Date Signed: _____