Mid Louisiana Surgical Specialists

A Professional Medical Corporation

General, Advanced Laparoscopic, and Robotic Surgery

Darryl J. Aguilar, M.D., F.A.C.S.
James N. Parrish, M.D., F.A.C.S.
Philip A. Cole, II, M.D.
S. Christopher Wheelis, M.D.

WELCOME!

As a new patient to Mid Louisiana Surgical Specialists we would like to extend a warm welcome to you. Your care and wellness are our primary goals.

Although our clinic is located in the doctor's building at Cabrini Hospital we are a complete and separate medical facility. This means we do not have access to any information you may have provided to Cabrini Hospital and will need to obtain that information from you. Please bring your original **health insurance card(s) and a photo identification,** such as a driver's license, with you to your appointment. We CANNOT accept copies or photos of your cards. In order to save you and our staff time, we have enclosed forms for you to complete prior to your visit. Please return the completed forms in the enclosed stamped envelope within FIVE DAYS of receiving them. If you have questions while completing the forms do not hesitate to call us. Remember, it is important that we receive the completed forms prior to your visit. Arriving for your visit without mailing in your forms **will** delay your seeing the doctor. It is very important that you complete the list of all medications you are currently taking, including the strength and dosage.

The staff members at Mid LA Surgical Specialists will make every effort for the doctor to see you in a timely manner. However, due to the nature of our specialty you may experience a longer than usual wait time. Our office has provided a comfortable waiting area with television and reading materials to help make your wait as pleasant as possible.

We wish to remind you of the importance of keeping medical appointments. Failure to keep appointments interferes with our ability to properly treat you and may jeopardize your health. If for any reason you feel that you will be late or will not be able to make your appointment, we would appreciate a telephone call at (318) 442-6767 so that we can schedule a later appointment for you and arrange for another patient to see the doctor at that time.

We thank you for putting your trust in us and look forward to serving you.

Physicians and Staff
Mid LA Surgical Specialists

Mid Louisiana Surgical Specialists

Patient Information Sheet

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION DATE: _____

First Name: _____ M.I. _____ Last: _____

Mailing Address: _____ City/St/Zip: _____

Home Phone: (___)_____ Work #: (___)_____ Cell #: (___)_____

E-mail: _____ Best Contact: ☐Email ☐Work ☐Cell ☐Home

Date of Birth: _____ Social Security #: _____

Sex: ☐ Male ☐ Female Marital Status: _____ Drivers License #: _____

Preferred Pharmacy: _____ Location: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City/St/Zip: _____

Person financially responsible for this patient:

Name: _____ SS #: _____

Date of Birth: _____ Employer: _____ Work Tel: (___)_____

Parent/Legal Guardian: _____ SS #: _____

Date of Birth: _____ Employer: _____ Work Tel: (___)_____

INSURANCE

Primary Insurance Company: _____

Policy Holder's Name: _____ DOB: _____

Relationship to patient: ☐ Self ☐ Spouse/Partner ☐ Child/Dependent ☐ Other

SS# _____ Policy/Member #_____ Group ID#_____

Secondary Insurance Company: _____

Policy Holder's Name: _____ DOB: _____

SS# _____ Policy/Member #_____ Group ID#_____

Is this a worker's compensation claim? ☐Yes ☐No Claim #: _____

Date of Injury: _____ Contact Person: _____ Tel: ( ) _____

(YOU MUST COMPLETE & SIGN THE BACK OF THIS FORM!)

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Tel (H): (____)_____ Tel (W): (____)_____ Cell: (____)_____

Address: _____

Do you have an Advance Directive? _____ Yes _____ No

REQUIRED INFORMATION

Medicare, in their efforts to assure that all patients have equal access to quality patient care, requires that we obtain the following information on all of our patients. We appreciate your assistance!

Do you consider yourself Hispanic/Latino? Yes No

Which category best describes your race? American Indian Asian Black/African American White Other:_____

PHOTO CONSENT - PROTECTED HEALTH INFORMATION

I understand that, in an effort to prevent medical identity theft, MLSS policy requires that my photo be placed in my medical record. I hereby consent to a photograph being made of me or my child/dependant. I understand that it is solely for the purpose of protecting my identity and protected health information_____

SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the physicians and staff on this case to release medical information to the pertinent insurance company(s) or third party carriers and request that payment be made directly to the billing entity. I also request that payment of benefits from my secondary insurance carrier be paid directly to the billing entity until otherwise notified.

OFFICE POLICY

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at the time of my visit.
3. I understand that I am required to pay my portion of any surgery/procedure charges prior to the procedure date.
4. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
5. I understand that my insurance card must be shown at each visit.
6. I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be canceled.
7. I understand that, in the event my account is turned over for collection, I will be responsible for payment of reasonable legal fees to collect same.
8. A copy of Mid Louisiana Surgical Specialists' financial policy has been made available to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Responsible Party

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Authorization for Release of Protected Health Information

Patient Identification

Patient Name _____ Date of Birth _____/_____/_____

Patient Address _____
Street City State Zip
Patient Social Security No. _____ Home Phone _____

Recipient Authorization

IMPORTANT!! *List all persons (doctors, family, friends, etc.) that you authorize Mid La Surgical Specialists to release your medical information to. **Anyone not listed will be unable to receive any of your medical information, written or verbal, from this clinic.*

I hereby authorize Mid La Surgical Specialists to release the information identified in this authorization form from the medical records of Mid La Surgical Specialists and provide such information to:

Referring physician(s)/Medical Facilities
List Physicians/Medical Facilities _____
_____
Family/Relative/Friend
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____

Information to be Released. Check all that apply and specify dates of service.

( ) Entire Medical Record _____ ( ) Lab Reports _____
( ) Visit Notes _____ ( ) X-Ray Reports _____
( ) Pathology Reports _____ ( ) Other (specify) _____

Purpose of Information Release

( ) Further medical care ( ) Disability Determination
( ) Payment of Insurance Claim ( ) Vocational rehab, evaluation
( ) Legal Investigation ( ) At the request of the individual
( ) Applying for Insurance ( ) Other (specify): _____

Inclusion of Privileged Information

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

Patient Rights and Privacy

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.

- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- I understand that Mid La Surgical Specialists will not deny treatment on whether I sign the authorization.

I hereby release and discharge Mid La Surgical Specialists of any liability, and the undersigned will hold Mid La Surgical Specialists harmless for complying with this Authorization.

Signature of Patient: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

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NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities
We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. You have certain rights and we have certain legal obligations regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations.

Uses and Disclosures: How we may use and disclose Health Information about you.

The following categories describe examples of the way we may use and disclose your health information:

For Treatment: We may use health information about you to provide you medical treatment or services. We may disclose health information about you to doctors, nurses, and technicians, medical students, or other Practice personnel who are involved in taking care of you. For example, your health information may be provided to a physician or other health care provider to which you have been referred.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery or other health care services so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Our Physicians may use information in your health record to assess the care and outcomes in your case. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professional;

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing companies, transcription companies, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your Medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible).

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives our Practice participates in.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

When We Must Obtain Your Authorization: We must obtain your authorization before using or disclosing health information for the following purposes:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health/Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies

- Funeral Directors and Coroners
- National Security and Intelligence Agencies/Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based cities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Rights Regarding Your Protected Health Information: You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request an Amendment:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Practice Privacy Official.

  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **Right to Restrict Uses or Disclosures:** You have a right to ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

  If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

  We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree,

we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The Practice will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the Practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the Practice and include the effective date. In addition, each time you come to the Practice for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

PRACTICE PRIVACY OFFICIAL

Practice Manager, 3311 Prescott Rd, Ste 201, Alexandria, LA 71301. Phone (318) 442-6767.

Patient's Name (please print)_____ Date:_____

Signature of Patient or Legal Guardian: _____

PLEASE SIGN AND RETURN ALL PAGES OF "NOTICE OF PRIVACY PRACTICES"

MID LOUISIANA SURGICAL SPECIALISTS
3311 Prescott Road, Suite 201
Alexandria, LA 71301
(318) 442-6767

Dr. Darryl J. Aguilar | Dr. James N. Parrish | Dr. Philip A. Cole II | Dr. S. Christopher Wheelis

NO SHOW/LATE CANCELLATION POLICY

Due to an increase in patient volume and an increase in failure of patients to appear for scheduled appointments and procedures, we are implementing a No Show/Late Cancellation policy.

Regarding Office/Clinic appointments:

If you fail to appear (No Show) for your scheduled office/clinic appointment without prior communication with the office staff, a **$50 Fee** will be charged to your account. The missed appointment will not be rescheduled until the fee is paid. The action of three No Shows may result in dismissal from the clinic. All dismissals are at the provider's discretion.

Regarding Scheduled Procedures:

If you fail to cancel your procedure at least **three business days** prior to your scheduled date, a **$100 Fee** will be charged to your credit card account. Your procedure will not be rescheduled until the fee is paid.

At the time of your initial visit to our clinic, you must provide credit/debit card information to be saved on file. If you fail to cancel your scheduled procedure within the specified time, as mentioned above, the appropriate fee(s), will be charged to the credit/debit card provided.

To reschedule your appointment, please call 318-442-6767.

Printed Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

Policy effective 05/27/2025

History and Physical

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Doctor: _____ **Family Doctor:** _____

Reason for visit: _____

PAST MEDICAL HISTORY - Check all that apply to YOU!

- □ None
- □ Number of Pregnancies _____
- □ Number of Births _____
- □ Asthma
- □ Atrial Fibrillation
- □ Anxiety
- □ Autoimmune Disorder
- □ CVA / Stroke
- □ COPD-Emphysema
- □ Coronary Heart Disease
- □ Crohn's Disease
- □ CRF-Renal Failure
- □ Colon Cancer
- □ Cataract Extraction
- □ Anesthesia Complications
- □ Blood Transfusion
- □ Depression
- □ Diabetes – Type 1
- □ Diabetes – Type 2
- □ GI Bleed
- □ G E R D - reflux
- □ Heart Disease
- □ Hyperlipidemia
- □ Hypertension
- □ Hypothyroidism-Underactive
- □ Hyperthyroidism-Overactive
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Infertility
- □ Cirrhosis
- □ DVT-blood clots
- □ Kidney Disease
- □ Kidney Stone
- □ Liver Disease
- □ M I-Heart Attack
- □ Neurologic Disorder
- □ Osteoathritis
- □ Osteoporosis
- □ PVD-arterial disease
- □ PUD – Gastric ulcers
- □ Rheumatoid Arthritis
- □ Skin Cancer
- □ Seizure Disorder
- □ Thyroid Disorder
- □ Tuberculosis
- □ Valvular Heart Disease
- □ U T I – bladder infections
- □ Brain Tumor
- □ Varicose Veins/Phlebitis
- □ Breast Disease
- □ Cervical Cancer
- □ Colon Polyps
- □ Fibromyalgia
- □ Breast Cancer
- □ Prostate Cancer
- □ Other _____

PAST SURGICAL HISTORY - Check all that apply to YOU!

- □ None
- □ Abdominal-exploratory
- □ Amputation
- □ Anesthesia Problems
- □ Aortic Valve Replacement
- □ Appendectomy
- □ Aortic Surgery
- □ Back Surgery
- □ Bladder Sling
- □ Brain Surgery
- □ Breast Biopsy
- □ C-Section
- □ CABG-Heart Bypass
- □ Carotid Endarterectomy
- □ Carpel Tunnel
- □ Cataract Surge
- □ Gallbladder
- □ Colon Resection
- □ Dialysis Access
- □ Gastric Bypass
- □ Gastric Sleeve
- □ Lap-Band
- □ Duodenal Switch
- □ Heart Stent
- □ Hemmorrhoidectomy
- □ Hernia Repair
- □ Hiatal Hernia Repair
- □ Hip Replacement
- □ Hysterectomy w/o ovaries
- □ Hysterectomy w/ ovaries
- □ Interventional Pain Procedure
- □ Kidney Surgery
- □ Knee Scope
- □ Knee Replacement
- □ Lung Surgery
- □ Mastectomy/Lumpectomy
- □ Mitral Valve Replace
- □ Pacemaker
- □ Parathyroidectomy
- □ Port Placement
- □ Port Removal
- □ Prostate Surgery
- □ Rotator Cuff Repair
- □ Surgical Complications
- □ Splenectomy
- □ Tubal Ligation
- □ Thyroidectomy
- □ Tonsillectomy
- □ Other_____

PAST FAMILY HISTORY - Check all that apply to IMMEDIATE FAMILY MEMBERS ONLY! List family member if applicable.

- □ FH Anemia _____
- □ FH Anesthetic Complication _____
- □ FH Blood Clots _____
- □ FH Breast Cancer _____
- □ FH Colon Cancer _____
- □ FH Ovarian Cancer _____
- □ FH Diabetes _____
- □ FH Heart Disease _____
- □ FH Hypertension _____
- □ FH Psychiatric Care_____
- □ FH Stroke _____
- □ FH Thyroid Disease _____
- □ FH Bowel Disease _____
- □ FH Kidney Disease _____
- □ FH Respiratory Disease_____
- □ FH Liver Disease _____
- □ FH Melanoma _____
- □ FH Weight Disorder _____

SOCIAL HISTORY – Circle/Complete all that apply to YOU!

MARITAL STATUS: Single Married Divorced Widow **LIVING ARRANGEMENTS:** Private Residence Nursing Home

ANY RELIGIOUS BELIEFS THAT WOULD AFFECT YOUR CARE? _____

TYPE OF WORK: _____ **LEVEL OF EDUCATION:** _____

Tobacco: □ Never □ Former □ Current:_____packs per day, for _____ months/years
If former tobacco user, how long since you last quit? _____months/years

Smokeless/Dip/Chew: □Never □ Former □ Current:_____ cans per day, for_____ months/years
If former smokeless user, how long since you last quit? _____ months/years

Vape: □ Never □ Former □ Current: _____ cartridges per day, for _____ months/years
If former vape user, how long since you last quit? _____ months/years

Are you exposed to secondhand smoke from someone else in the household? □ YES □ NO

Alcohol: □ Never □ Former □ Current: _____ drinks per day

Drug use: □ Never □ Former □ Current: _____ substance

Are you at risk for HIV: □ YES □ NO

Regular Exercise: □YES □ NO How many times per week? _____

Date of last Colonoscopy: _____ **Date of Last Mammogram:** _____

Review of Systems

Check all that apply to YOU!

GENERAL
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Unexplained Weight Loss

EYES
- □ Double vision
- □ Recent change in vision
- □ Eye pain
- □ Do you wear contacts/glasses? Yes No

GASTROINTESTINAL
- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Change in bowel habits
- □ Melena
- □ Blood in stool
- □ Jaundice
- □ Gas/bloating
- □ Indigestion/heart burn
- □ Dysphagia-difficulty swallowing

BREAST
- □ Left breast lump
- □ Right breast lump
- □ Nipple discharge
- □ Bloody nipple discharge
- □ Breast pain
- □ Abnormal mammogram
- □ Breast Enlargement
- □ Nipple/breast rash

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations-skipped beats
- ☐ Dizziness
- ☐ Fainting
- ☐ Peripheral edema-ankle swelling
- ☐ Shortness of breath

RESPIRATORY
- □ Cough
- □ Shortness of breath
- □ Coughing up blood
- □ Wheezing
- □ Pleuritic chest pain

VASCULAR
- □ Varicose veins
- □ Leg swelling
- □ Leg redness
- □ Leg coolness
- □ Pain in legs when walking
- □ Resting leg pain
- □ Pain in legs at night
- □ Blue toe(s)

GENITOURINARY (Female)
- □ Vaginal discharge
- □ Incontinence-urine leakage
- □ Dysuria-painful urination
- □ Blood in urine
- □ Is there a chance you are pregnant? Yes No
- □ Frequent urination
- □ Abnormal Vaginal bleeding
- □ Pelvic Pain

GENITOURINARY (Male)
- □ Painful urination
- □ Blood in urine
- □ Discharge
- □ Frequent urination
- □ Frequent night urination
- □ Difficulty urinating
- □ Incontinence-urine leakage
- □ Erectile dysfunction

WOUND
- □ Wound redness
- □ Wound drainage
- □ Wound pain
- □ Opening of wound
- □ Bleeding from wound
- □ Non-healing wound

DERMATOLOGY
- □ Suspicious lesions
- □ New skin lesions
- □ Changing mole(s)
- □ Rash
- □ Itching
- □ History of skin cancer
- □ SQ nodules (lumps)

NEUROLOGICAL
- □ Paralysis
- □ Numbness of an extremity
- □ Seizures
- □ Frequent headaches

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Memory loss
- □ Suicidal thoughts
- □ Hallucinations
- □ Paranoia
- □ Phobia
- □ Confusion

ENDOCRINE
- □ Cold intolerance
- □ Heat intolerance
- □ Excessive thirst
- □ Excessive eating
- □ Unusual weight change

HEME
- □ Abnormal bruising
- □ Bleeding
- □ Enlarged lymph nodes
- □ Sickle cell anemia
- □ Recent fever infections

MUSCULOSKELETAL
- □ Back pain
- □ Sciatica-nerve issues
- □ Arthritis
- □ Bone/joint pain

OTHER
- □ Stoma redness
- □ Pain around stoma
- □ Discharge from stoma
- □ Pain from venous catheter
- □ Redness at vascular access site
- □ Purulent drainage from vascular access site.

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MEDICATION FLOW SHEET

Name: ______________________________ DOB: ______________ Weight: __________

Allergies: ____

____

MEDICATION HISTORY CONSENT

An accurate medication history is very important in helping our physicians provide you with quality health care and assists in avoiding potentially dangerous drug interactions.

I hereby give my consent to Mid Louisiana Surgical Specialists to electronically obtain my medication history.

____

Patient Signature / Legal Guardian

*Electronic information from your pharmacy and/or health insurance provider might not be complete. It's very important that you inform your physician of all medications that you routinely take, including over-the-counter medicine, vitamin supplements and herbal remedies.

Date	Medication	Unit Dose	How often do you take it?	MD/Nurse

Mid Louisiana Surgical Specialists

Dr. James N. Parrish
Alexandria Bariatric Surgery

WELCOME!

As a new patient to Alexandria Bariatric Surgery, we would like to extend a warm welcome to you. Your decision to pursue bariatric surgery was not an easy one and we thank you for allowing us to assist you on your journey. Our goal is to provide you with a pathway of valuable resources and education that will keep you on the right track as you take each step in our program.

Depending on your current state of health and insurance requirements there may be various types of testing, clearances and visits to other clinicians that will be necessary to complete this process. We encourage you to keep up with your progress so that as things evolve, we both have the most up to date information. This will help you reach not only your long-term health goals but also achieve greater success in your commitment towards the program.

We encourage you to read through this entire packet and allow those who are supporting you to read through it as well. Should you have any questions, please contact our Bariatric Team to further discuss.

Sincerely,

Dr. James N. Parrish and The Bariatric Team

Mid Louisiana Surgical Specialist – Dr. James N. Parrish
3311 Prescott Road, Suite 201
Alexandria, LA 71301
Office: 318-442-6767 Fax: 318-449-3986
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Commercially Insured Patients

Dear Patient,

We are excited for you to begin your journey with our office. We look forward to assisting you in every way to make this process as easy as possible. We make every effort to correctly verify your insurance coverage and benefits prior to your initial visit with us. Unfortunately, inaccurate information has been shared with our office during attempts to gather benefit details. This inaccurate information has led to denials after completion of the surgical workups. **To reduce the likelihood of erroneous information and prevent unnecessary medical costs to you, we encourage you to obtain your medical plan documents to confirm your Bariatric coverage.** This includes but is **not limited** to Aetna, Blue Cross Blue Shield, Cigna, Humana, and United Healthcare.

We recommend all patients call the insurance company themselves to verify coverage for bariatric services and confirm the results of our verification. Patients can typically call the number on the back of their insurance card, speak with the human resources department of their employer or insurance broker. Upon receipt of your plan documents, we will be happy to discuss your coverage information.

If you have any questions, please do not hesitate to give our office a call.

Thank you,

Dr. James N. Parrish and The Bariatric Team

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Office Co-Payment and Surgical Payment Policy

Please read the following policy and initial by each statement acknowledging your understanding of the financial responsibilities and that all questions have been answered to your satisfaction.

As a courtesy, we will verify your benefits with your insurance company. A quote of benefits is **not a guarantee of coverage or payment from your insurance company**. All claims will process according to your plan benefits at the time services are rendered. If your claim processes differently from the benefits we are quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

Although we are contracted with most insurance carriers, some services may not be covered by your insurance plan. Being referred to our office by another physician does not guarantee that your insurance will cover our services. Please remember that you are fully responsible for all charges incurred that are not covered by your insurance plan. Your physician's referral and our verification of your insurance benefits are **not a guarantee of payment**.

It is the policy of Mid Louisiana Surgical Specialists that payment is due at the time of service. We do require all patients to pay their copays, deductibles, and/or coinsurance payment at the beginning of each visit. All surgical coinsurance, deductibles, out of pocket, or private pay responsibilities will be collected PRIOR to the date of surgery.

Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

_____ **Initial**

Bariatric Lifetime Maximums

Although your insurance plan may cover bariatric services, some policies will only allow for a maximum amount of bariatric office visits and bariatric surgeries per lifetime of that plan. Some insurance policies will only cover ONE bariatric surgery per lifetime of that policy. We make every effort to correctly verify your insurance coverage and benefits prior to your initial visit with us. Choosing the appropriate bariatric surgery along with the physicians' recommendations for you and your health are of **great importance**. If any revisional bariatric surgeries are desired in the future due to failed weight loss or mechanical complications, some plans will NOT cover any additional surgeries regardless of medical conditions or medical necessity therefore any completion of these additional services will be solely the patient's financial responsibility.

_____ **Initial**

Office Visits and Appointments

In the event you are unable to keep a scheduled appointment, we do ask that you cancel or reschedule at least 24 hours prior to your visit. Failure to do so **will require a $50 fee** to reschedule for all no showed appointments.

_____ **Initial**

Surgery Cancellation

We fully recognize that at times patients cannot make their surgical date due to unforeseen circumstances. Due to the significant time and effort made to reschedule surgeries, and the implications of rescheduling other patients, failing to cancel your procedure at least three business days prior to your scheduled date **a $100 fee** will be charged to your account. Your procedure will not be rescheduled until the fee is paid.

_____ **Initial**

Bariatric Guidelines for Surgery

Please read the following guidelines and initial by each statement acknowledging your understanding of the program requirements and that all questions have been answered to your satisfaction.

Surgical Clearances

There may be various types of testing, clearances and visits to other clinicians that will be necessary to complete the bariatric program. Most clearances are only good for up to 6 months and expire after that time frame. It is extremely important to keep up with all scheduled clearances in a timely manner. Any non-compliance with scheduled testing, specialist clearances or other program requirements will result in repeating them until completion. This may extend the length of time it takes before you are able to schedule surgery. All patients MUST be appropriately cleared and required testing resulted to our office BEFORE surgery can be scheduled.

_____ Initial

Nicotine Free

Nicotine comes in various forms, all of which need to be stopped before surgery. This includes cigarette smoking, nicotine gum, nicotine patches, cigars, snuff, and vaping. Even secondhand smoke can be consequential.

Nicotine affects wound healing, both inside and out. Safe and successful bariatric surgery depends on the healing of staple lines and bowel connections. Failure to comply can result in catastrophic outcomes and even result in death. As such, all patients undergoing any bariatric surgery MUST **be nicotine free for 30 days prior to any operation**. We reserve the right to check nicotine levels and cancel operations if nicotine is detected. You will test for nicotine during the program, before surgery, and the morning of your procedure.

Nicotine use post-operatively can also cause multiple issues including marginal ulcers, bleeding, strictures, perforation, and death. It is highly advised to discontinue **ALL** nicotine products indefinitely following surgery. Non-compliance with nicotine use can also result in insurances no longer covering bariatric services and/or surgery.

_____ Initial

Pregnancy Recommendations

Bariatric surgery results in significant weight loss. During times of weight loss, vitamin levels can be unstable and as such, getting pregnant after weight loss surgery can be harmful to the developing fetus. Additionally, hormone-based birth control can be unreliable as fat masses are decreased. We highly recommend other birth control measures (i.e.: condoms, diaphragms, cervical cap/sponge, and abstinence) be taken and pregnancies avoided for 18 months after surgery. You will be required to stop all hormonal birth control methods 1 month prior to surgery and not be restarted until 1 month following surgery.

_____ Initial (*Female Patients Only)*

Fluids and Post Op Diet/Nutrition

Dehydration is the number one reason that most patients return to the hospital after bariatric surgery. It is important to stay hydrated by drinking 64 ounces of fluid per day (approximately 4 ounces of fluid each hour). Remember to record your fluid intake daily to stay on track. Taking sips of the recommended liquids should be done every 10 to 15 minutes following surgery.

You will be discharged from the hospital on a liquid diet. Once you can advance to the next phase of your nutrition plan you **must strictly adhere** to the weekly set stages of post op eating and lifestyle changes. Progressing too quickly may cause abdominal pain and vomiting. **Failure to adhere to these set changes may result in weight gain**. Non-compliance can also result in some insurances no longer covering bariatric services.

_____ Initial

Vitamins

After bariatric surgery, a lifelong commitment to the appropriate vitamin supplementation is paramount to ensure that your levels for your body's essential functions are optimal. We will provide you with a list of what vitamins you will need. We also provide vitamins for sale direct through our office, or they can be purchased online through our website anytime to be shipped directly to you at www.alexandriabariatricsurgery.com

_____ Initial

Routine Medications after Bariatric Surgery

Some medications will need to be avoided or stopped completely for life following bariatric surgery. It is important to discuss all prescription medications or over the counter medications you take with Dr. Parrish.

Any use of the following medications whether prescribed or over the counter may cause damage to the stomach/pouch, gastric intestinal bleeding, or possible ulceration.

NSAID's (non-steroidal anti-inflammatory drugs): Aspirin, Advil, Aleve, Bayer, Excedrin, Midol, Motrin, Pamprin, Naproxen, BC Powder, etc.

_____ Initial

Follow Up Appointments

Following your bariatric surgery, you will continue to see Dr. Parrish or one of our Physician Assistant's for aftercare. **It is of most extreme importance to continue these follow-up appointments for life as they will further a successful outcome in your weight loss goals.** During these follow-up appointments we will track your progress and document your success. This will keep you on course to maintain a healthy lifestyle after surgery and lessen your chances of any weight gain following surgery. **Failure to adhere to the follow-up recommendations may result in weight gain.** Non-compliance can also result in some insurances no longer covering bariatric services.

FOLLOW-UP APPOINTMENTS ARE FOR LIFE!!

This is the biggest key to a patient's success and long-term health goals. Please keep up with ALL follow-up appointments as required per our office.

_____ Initial

Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

BARIATRIC PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Primary Care Doctor: _____ Referring Doctor: _____

OBESITY HISTORY

List all physicians who have provided you with medical care during the past three years:

_____

_____

_____

_____

_____

DIET HISTORY

Types of Weight Loss Programs:	Yes/No
Supervised Diets	
Unsupervised Diets	
Prescription Diet Pills (adipex, phentermine, Ozempic, Wegovy, etc.)	
Nonprescription Drugs for Weight Loss (over the counter – Hydroxy cut, Alli, Green Tea, etc.)	
Psychotherapy	
Behavior Modification	
Weight Watchers	
Other – Please List	
Other – Please List	

PSYCHOLOGICAL HISTORY

Have you ever or are you currently under treatment for: Alcohol Abuse/Addiction **Yes or No**

Have you ever or are you currently under treatment for: Drug Abuse/Addiction **Yes or No**

Psychological Disorders:	Yes/No		Yes/No
Nervous Breakdown		Suicide Attempts	
Depression		Schizophrenia	
Forced Vomiting after meals (Bulimia)		Other:	
Bipolar Disorder		Other:	

If you checked any of the above, please explain: _____

_____

SLEEP DISORDER ASSESMENT

Have you been diagnosed with Sleep Apnea? **Yes or No**
Do you have a CPAP or any other sleep apnea machine? **Yes or No**

Please choose **YES** or **NO** to the following to find the likelihood of your risk for Sleep Apnea.

Have you been told that you snore?	YES	NO
Are you often tired during the day?	YES	NO
Do you stop breathing or has anyone witnessed you stop breathing during sleep?	YES	NO
Do you have a diagnosis of high blood pressure (hypertension) or do you take medicine for high blood pressure (hypertension)?	YES	NO
Is your BMI greater than 35?	YES	NO
Is your age 50 years or older?	YES	NO
Is your neck circumference 17 inches or greater if biological sex is male, or 16 inches or greater if biological sex is female?	YES	NO
Is your biological sex male?	YES	NO

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you haven't done any of these activities recently, please try to estimate how you would typically respond.

For each situation, decide whether you would have:

No chance of dozing = 0
Slight chance of dozing = 1
Moderate chance of dozing = 2
High chance of dozing = 3

Write down the number corresponding to your choice in the right-hand column.

Situation	**Chance of Dozing Off/Sleeping**
Watching TV	
Sitting and reading	
Sitting and Talking to Someone	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	