Atrium Health

VERIFY INSURANCE BENEFITS

_____ Call your insurance company to make sure you have benefits to pay for bariatric surgery. The 1-800# is located on the back of your insurance card. Simply ask “Do I have bariatric surgery coverage?”

_____ Ask: “Do I have to complete a medically supervised weight-loss program before surgery?” If yes, how many months?

_____ If you have Aetna ask “Does my plan require an Institute of Quality?

_____ If you have United Healthcare ask “Does my plan require a Center of Excellence?

_____ The insurance company may ask for a procedure code (CPT code) when you call to verify coverage.

CPT Codes:	Procedure:
43644	Laparoscopic Roux-en-Y Gastric Bypass
43775	Laparoscopic Vertical Sleeve Gastrectomy
43775/43659	Laparoscopic Duodenal Switch
43770	Laparoscopic Adjustable Gastric Band

I understand that verifying my insurance for bariatric surgery coverage is my responsibility.

_____

Patient signature/date

Dear Interested Surgical Candidate,

We would like to take this opportunity to thank you again for choosing **Atrium Health Weight Management.** By attending our informational session, you should have many of your questions answered. By attending the session and seeking more information, you have made steps towards a life changing decision. There are many guidelines in the program that are necessary for your surgical care. We want you to be prepared and informed as our patient. The goals of our team are to provide you with excellent care, education, and assistance throughout the surgical process.

You will need to actively participate in a multidisciplinary program for bariatric surgery which includes nutrition, behavioral and exercise counseling. Our highly trained team is committed and excited to partner with you on your journey to better health.

Please read and fill out all the forms provided in this packet. **Please do not date anything in the packet until the day of your appointment. It is mandatory that you bring the completed packet with you to your initial surgical appointment. Failure to complete the packet before your appointment may result in rescheduling the appointment.** Please do not mail or fax in the packet. If you would like a copy of the packet for your records, please make a copy prior to your office visit.

If you have questions about the packet, please phone our Bariatric Hotline at 704-355-9484. If you must cancel your appointment for any reason, please contact our office as soon as possible to reschedule. Failure to cancel your appointment 3 times will result in you being dismissed from the practice. This is an Atrium Health policy.

At your initial appointment you will need to bring your insurance cards, specialty co-pay or $50 towards your deductible, and your completed packet.

We look forward to meeting with you soon!

Sincerely,
Your Bariatric Surgery Team

If you would like to verify that your insurance provider covers bariatric surgery on your specific plan or the cost estimates of the procedures, provide them with the CPT codes listed below. If you need information on surgery costs, you may call the “Insurance & Price Estimation” hotline at 704-355-0900.

CPT Codes:	Procedure:
43644	Laproscopic Roux-en-Y Gastric Bypass
43775	Laproscopic Vertical Sleeve Gastrectomy
43775/43659	Laproscopic Duodenal Switch
43770	Laproscopic Adjustable Gastric Band
97802	Medical Nutrition Therapy—Initial visit
97803	Medical Nutrition Therapy—Follow-up visit
97804	Medical Nutrition Therapy—Group visit

Atrium Health Weight Management
2630 E. 7th Street, Suite 100
Charlotte, NC 28204
704.355.9484

From I-77 South:

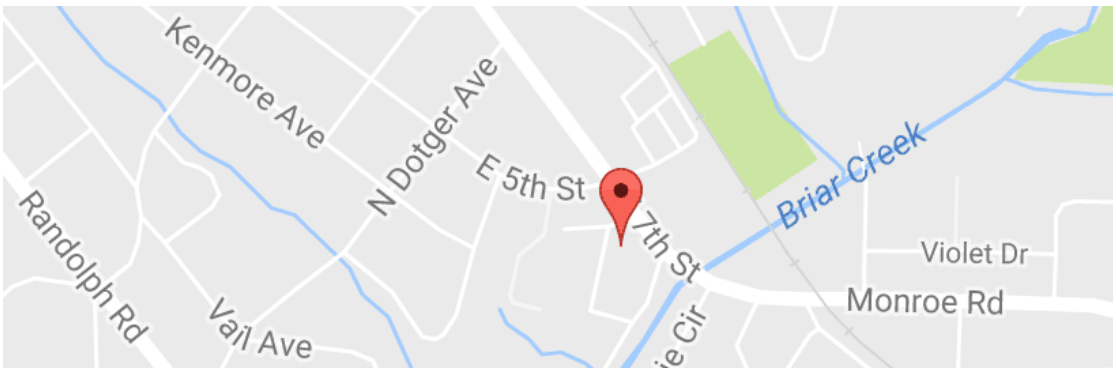
Start at I-77
Take exit #9/JOHN BELK FRWY/WILKINSON/onto I-277 North towards 9B/JOHN BELK FRWY
Take exit #2A/KENILWORTH AVE/THIRD ST/FOURTH ST towards THIRD ST/FOURTH ST.
Take the 3rd ST. Exit
Take a Right on to 3rd St; then get in your far left lane.
Take a Left on to KINGS DR. Go pass CPCC College, continue until you see E 7th ST.
Take a Right on E 7TH ST.
At the intersection of E. 5th ST, (on the Right) and Firefighter St (on your left), go through the stop light.
2630 E 7th ST is the second driveway on your Right. (Eastover Medical Park III—only 2 story building)
If you go to Lupie's Restaurant you have gone too far.

From I-85 South:

Take I-85 North.
Take exit #36/BROOKSHIRE FREEWAY/DOWNTOWN (US-74 EAST) onto BROOKSHIRE FREEWAY (NC-16 S) toward Charlotte/Bank of America Stadium.
Take the BEVARD ST/DAVIDSON ST/MCDOWELL ST exit.
Continue on N. MCDOWELL ST.
Turn Left on E.7th ST. (NC-27).
Continue on E.7th ST. at the intersection of E.5th ST. (on the Right) and Firefighter St on your Left go through the stop light.
2630 E 7th ST will be the second driveway on your Right. (Eastover Medical Park III—only 2 story building)
If you go to Lupie's Restaurant you have gone too far.

From I-85 North:

1. Take I-85 South
2. To I-77 South
3. Take exit 11 for I-277 S/Brookshire Freeway E/NC- 16 S
4. Take exit 2B on the left US-74 E/NC 27 E toward Independence Blvd
5. Slight Right at Briar Creek Rd, then turn left onto Briar Creek.
6. Turn Right at Monroe Rd
7. Continue on E 7th St.
8. Once you pass Lupie's Restaurant on your left, go to the 1st drive way on the Left. (Eastover Medical Park III—only 2 story building)
9. If you go to the stop light at the intersection of E.5th and Firefighter St, you have gone too far.



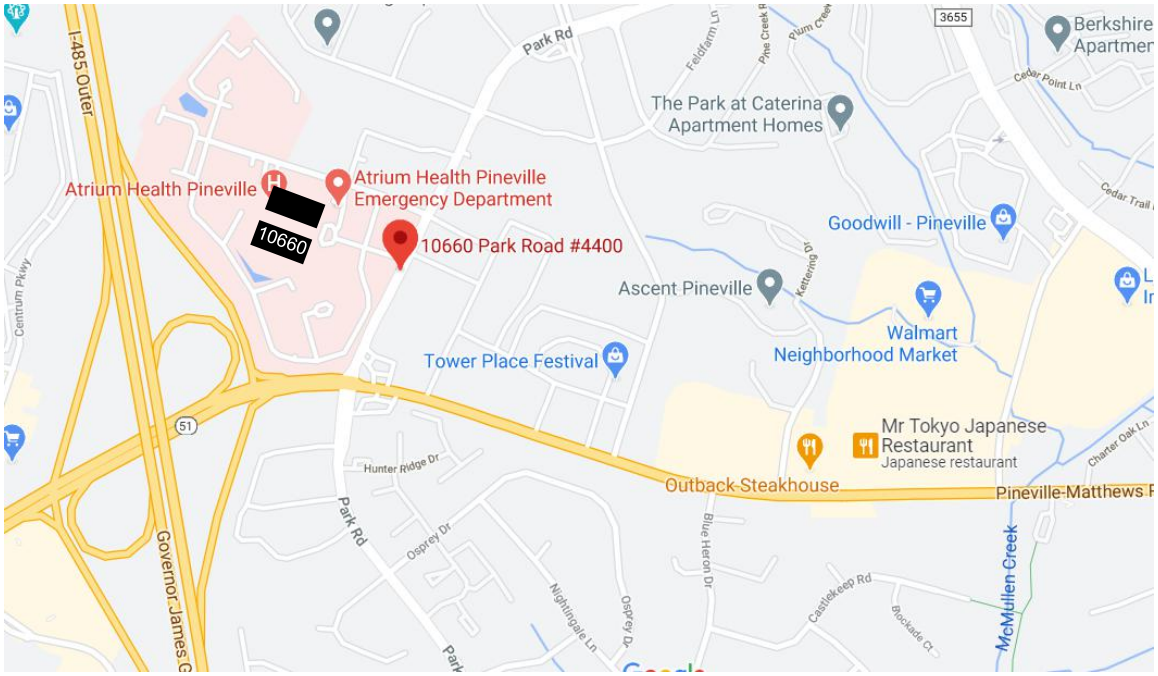
Atrium Health Weight Management
Pineville Office

Pineville Office Address
10660 Park Rd., Suite 4400, Charlotte, NC 28210

Phone Number's
704-667-2681—Pineville office
704-355-9484—Main office

Directions
From I-485, Take Exit 64A for US 51 (Pineville Matthews Rd)
Stay in the far left turning lane
Turn Left onto Park Road
Turn Left into Atrium Health Pineville Entrance
Take the first left turn if you would like to park in the top parking lot or parking deck. Take the second left if you would like to park in the bottom parking lot (closest to building). When entering building: enter through side entrance of building 10660. You will be screened at the front desk for temperature and COVID-19 symptoms. Take elevator to the 4th floor. Turn left out of elevator and walk to back of the building, suite 4400 will be on the right.

Please arrive 20 minutes before your scheduled appointment to ensure that you arrive on time.



Atrium Health Weight Management
Gastonia Office

Gastonia Office Address
2550 Court Drive #202, Gastonia, NC 28054

Phone Number's
704-861-2290—Gastonia
704-355-9484—Main office

Directions
From Charlotte:
Take I-85 S to exit 21 (Cox Road)
Turn Left onto Court Drive, office will be on the right.

From Kings Mountain:
Take I-85 N to exit 20 (NC-279/New Hope Rd)
Turn Let onto NC-279 W/N New Hope Rd
Turn Right onto Court Drive, office will be on the left

Atrium Health Weight Management—Concord Office

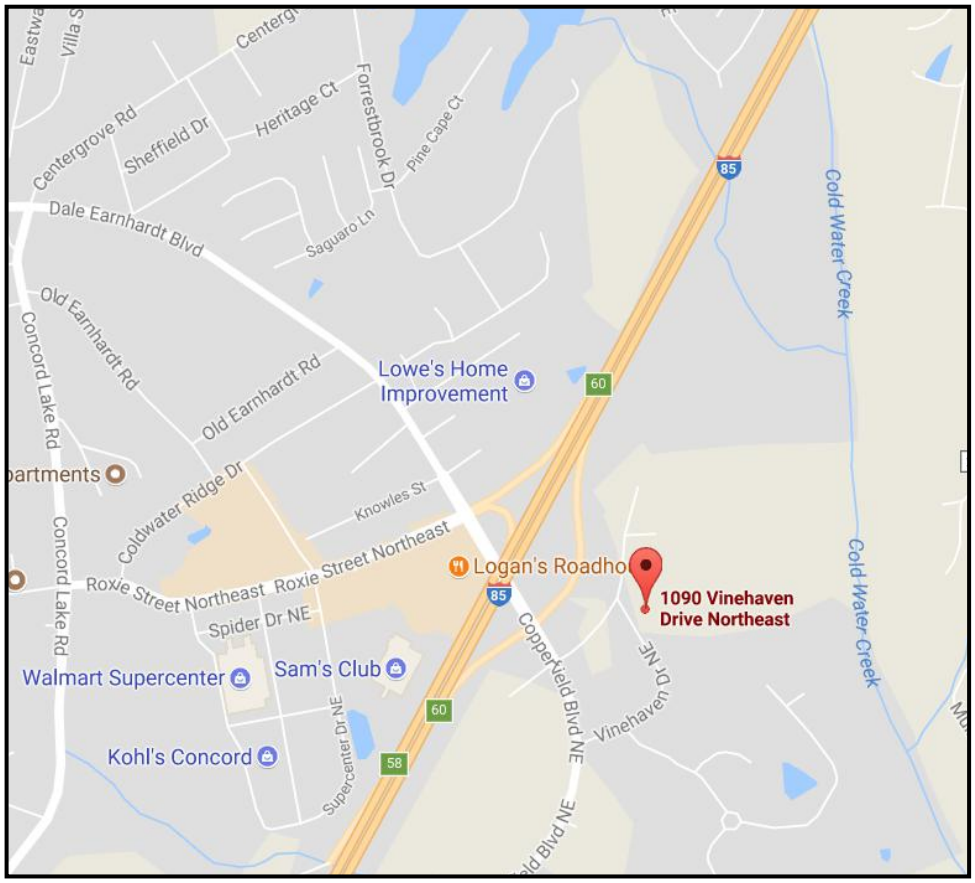
1090 Vinehaven Drive NE, Concord, NC 28025

704-403-7580 Office

704-403-7581 Fax

From I-85:

- Take Exit 60
- At the top of the ramp, turn right onto Copperfield Blvd. NE
- Take first left onto Dicken's Place NE
- Take first right onto Vinehaven Drive NE
- Destination will be on the left



ATRIUM HEALTH WEIGHT MANAGEMENT

BMI CHART

Body Mass Index (BMI) is a number calculated from an individual's height and weight that is used to determine whether a person is within a normal weight range.

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
	Normal						Overweight					Obese					Morbid Obesity															Super Obesity												
Height↓	Weight in Pounds→																																										
4"10"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258	263	268	273	278	283	287
4'11"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267	272	277	282	287	292	297
5' (60")	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276	280	285	290	295	300	305
5'1"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285	290	295	300	305	310	315
5'2"	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295	300	305	311	317	322	328
5'3"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304	310	316	321	327	333	339
5'4"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314	320	326	332	338	344	349
5'5"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324	330	336	343	348	354	360
5'6"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334	340	347	354	360	365	371
5'7"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344	351	357	364	370	376	383
5'8"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354	361	369	375	381	388	395
5'9"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365	372	379	387	393	399	406
5'10"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376	383	390	397	404	411	418
5'11"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386	394	401	408	416	422	430
6' (72")	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397	405	412	420	428	435	442
6'1"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408	416	424	432	440	447	455
6'2"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420	428	436	444	452	459	467
6'3"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431	440	448	456	464	472	480
6'4"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443	452	460	468	476	485	493

For medical appointments, questions or to sign up for a Surgical Information Session, please phone:

"THE BARIATRIC HOTLINE"

704-355-9484

www.carolinasweightmanagement.org

Surgical Patient History Form

Name:_____DOB:_____/_____/_____

Which surgical procedure are you interested in? (please check box)

☐ Gastric Bypass ☐ Sleeve Gastrectomy ☐ Lap Band ☐ Revision of Previous Surgery ☐ Undecided

Medical History **(Please circle yes or no to the following questions)**

Has a Doctor or Health Professional ever told you that you have or treated you for any of the following?

Nervous System:

Stroke, mini stroke, or one-sided weakness?	NO	YES
Chronic headaches/migraines?	NO	YES
Seizures?	NO	YES
Numbness or tingling in neck, arms or hands?	NO	YES

Heart and Circulation:

High blood pressure?	NO	YES
High cholesterol?	NO	YES
Congestive heart failure?	NO	YES
Heart attack?	NO	YES
Heart valve abnormalities?	NO	YES
Abnormal heart rhythms?	NO	YES
Do you ever experience chest pain or palpitations?	NO	YES
Symptoms with exercise?	NO	YES

If yes, explain:_____

Heart stress test?	NO	YES
Cardiac catheterization or angioplasty?	NO	YES
Pacemaker or implantable defibrillator?	NO	YES

Lungs and Breathing:

Sleep apnea?	NO	YES
CPAP or BIPAP machine?	NO	YES
Have you ever had a sleep study?	NO	YES
Asthma?	NO	YES
Emphysema or COPD?	NO	YES
Pulmonary embolus?	NO	YES

How many blocks can you walk without becoming short of breath?
(Please circle one of the choices below)
Less than ½ block ½ block 1 block 1-2 blocks more than 2 blocks

Physician use only

HT_____

WT_____

BMI_____

PCP:_____

INS:_____

Patient Information or Label

Name:
DOB:
Medical Record #:

Name:_____DOB:_____/_____/_____

Liver, Gallbladder, Stomach, Intestine:

GERD/Acid Reflux?	NO	YES
Heartburn?	NO	YES
If yes, how many times per week?	____ times/week	
Difficulty swallowing food or liquid?	NO	YES
Gallstones?	NO	YES
Pancreatitis?	NO	YES
Cirrhosis?	NO	YES
Stomach/duodenal ulcers?	NO	YES
Hiatal hernia	NO	YES
Hepatitis (A, B or C)?	NO	YES
Crohns/Ulcerative Colitis?	NO	YES
Irritable Bowel Syndrome?	NO	YES
Chronic constipation?	NO	YES
History of GI cancer?	NO	YES
Have you ever had a colonoscopy, barium enema or upper endoscopy?	NO	YES

If yes, include the date and reason why:

_____

_____

_____

_____

Blood and Clotting:

Will you accept a blood transfusion if necessary?	NO	YES
Anemia?	NO	YES
Sickle Cell disease?	NO	YES
Clotting or platelet disorder?	NO	YES
Deep Venous Thrombosis (DVT – blood clot in your arm, leg, chest, etc?)	NO	YES
Have you ever been on Coumadin?	NO	YES

Are you on any of the following?

Aspirin Plavix NSAIDs (Ibuprofen, Advil, Motrin, Naprosyn)

Physician use only

*Will patient accept blood products?

☐ Yes ☐ No

*Procedure discussed?

☐ Yes ☐ No

Atrium Health

Atrium Health Weight Management

Surgical Patient History Form

Patient Information or Label

Name:

DOB:

Medical Record #:

Name:_____DOB:_____/_____/_____

Endocrine:

Diabetes?	NO	YES
Thyroid disease?	NO	YES
Polycystic ovarian syndrome? (PCOS)	NO	YES
Cushings Disease?	NO	YES
Excessive thirst, hunger, urination?	NO	YES
Visual changes (wavy lines, spots)?	NO	YES
Change in body temperature (very cold or hot)?	NO	YES

Miscellaneous:

Depression?	NO	YES
Schizophrenia	NO	YES
Other psychiatric disorder?	NO	YES
Joint pain (hip, knee, ankle, lower back)?	NO	YES
If yes, circle areas that are affected		
Lower back hip knee ankle		
Urinary stress incontinence?	NO	YES
If yes, how many pads do you use per day	_____ pads/day	
Kidney Stones and/or other kidney disease?	NO	YES
HIV?	NO	YES
Autoimmune disease (rheumatoid arthritis, Lupus, etc.)	NO	YES

If yes, please explain:

_____

_____

_____

Pregnancy History:

How many times have you been pregnant? _____

How many times have you delivered? _____

Have you ever had a c-section?	NO	YES
If yes, how many? _____		
Complications following delivery or c-section?	NO	YES
Problems during pregnancy (high BP or blood sugar)?	NO	YES
Have you ever had a tubal ligation?	NO	YES
Have you ever had problems becoming pregnant?	NO	YES

If yes, please explain:

_____

_____

Physician use only

Atrium Health

Atrium Health Weight Management

Surgical Patient History Form

Patient Information or Label

Name:

DOB:

Medical Record #:

Name:_____DOB:_____/_____/_____

Surgical History:

Have you ever had prior surgery? NO YES

Have you ever had weight loss surgery? NO YES

If yes, list all surgeries that you have had and the year in which they occurred?

_____

_____

_____

_____

Have you ever experienced any of the following after surgery?

Blood clots NO YES

Abnormal bleeding NO YES

Problems with anesthesia NO YES

If yes, please explain:

_____

_____

Difficulty healing? NO YES

If yes, please explain:

_____

_____

Drug Allergies? NO YES

If yes, describe the reaction you had:

_____

_____

Social History:

Current Smoker? NO YES

If yes, how much do you smoke (pack(s)/day): _____ pack(s)/day

How many years have you smoked? _____years

Past smoker? NO YES

If yes, indicate the number of months since you quit: _____months

Drink alcoholic beverages? NO YES

If yes, indicate the number of drinks/week: _____drinks/week

Current IV drug use? NO YES

Past IV drug use? NO YES

Physician use only

Atrium Health

Atrium Health Weight Management

Surgical Patient History Form

Patient Information or Label

Name:

DOB:

Medical Record #:

Name:_____DOB:_____/_____/_____

Social History (continued):

Do you live alone?	NO	YES
Do you use a wheelchair or walker?	NO	YES

Occupation:_____

Family History (parents and siblings):

Check here if your family history is unknown ☐

Obesity	NO	YES
High cholesterol	NO	YES
Bleeding	NO	YES
Diabetes	NO	YES
High blood pressure	NO	YES
Heart disease	NO	YES
Heart attack	NO	YES
DVT (blood clots in arm, leg, chest, etc.)	NO	YES
Cancer	NO	YES
Anesthesia difficulty	NO	YES
Sleep apnea	NO	YES
Asthma	NO	YES

Please check all previous weight loss program or medications you have tried:

Program	**Date**	**Weight (lost or gained)**	**Length of participation**
Weight Watchers	_____	_____	_____
Overeaters Anonymous	_____	_____	_____
Liquid diets (optifast)	_____	_____	_____
Diet pills (phen-fen, redux)	_____	_____	_____
Diet pills (meridian, Xenical)	_____	_____	_____
Diet pills (phentermine)	_____	_____	_____
Diet pills (Topomax)	_____	_____	_____
Nutrisystem	_____	_____	_____
Jenny Craig	_____	_____	_____
OTC diet pills	_____	_____	_____
Nutritionist/Dietitian	_____	_____	_____
Surgery	_____	_____	_____

Other_____

_____

_____

Physician use only

Atrium Health

Atrium Health Weight Management

Surgical Patient History Form

Patient Information or Label

Name:

DOB:

Medical Record #:

Name:_____DOB:_____/_____/_____

Current Medications:

Please include all prescriptions and over the counter medications, herbs and vitamins. You may bring a separate list.

Medication	Dose	Frequency

Physician use only

Atrium Health

Atrium Health Weight Management

Surgical Patient History Form

Patient Information or Label

Name:

DOB:

Medical Record #:

Atrium Health Weight Management
Patient's Physician Information

Patient's Name:_____
(First) (M.I.) (Last)

Primary Care Physician: _____
(First) (M.I.) (Last)

Practice Name:_____

Practice Address:_____

City/State:_____

Phone #:_____Fax:_____

Referring Physician: _____
(First) (M.I.) (Last)

Practice Name:_____

Practice Address:_____

City/State:_____

Phone #:_____Fax:_____

Specialist Physician: _____
(First) (M.I.) (Last)

Practice Name:_____

Practice Address:_____

City/State:_____

Phone #:_____Fax:_____

Other Physician: _____
(First) (M.I.) (Last)

Practice Name:_____

Practice Address:_____

City/State:_____

Phone #:_____Fax:_____

Patient Information or Label

Name:

DOB:

Medical Record #: