

David D. Kim M. D. Personal Information

Name:		Name you wish to be called:	
Male	Female	Minor	Ethnicity:
Address		City	State Zip
DOB:		Social Security #:	
Employer:		Occupation: Full time or Part time	
Family Physician:		Referring Physician:	
Cardiologist:		Psychologist/Psychiatrist:	

Telephone

Home:		Work:		Alternative:	
Cell:		Email:			
Where do you prefer to receive calls?	Work	Home	Cell	Alternate	May we leave a message? Yes No
Can we communicate through Email?	Yes	No			
When is the best time to reach you?	Time:		Day:		
Pharmacy:			Phone:		
In the event of an emergency, who should we contact?					
Name:			Home:		
Relationship:			Work:		

Insurance Information

Primary Insurance	Secondary Insurance
ID#	ID#
Group#	Group#
Insurance Co. Address & Phone Number:	Insurance Co. Address & Phone Number
Policy Holder Information Name:	Policy Holder Information: Name:
Employer:	Employer:
Occupation: Full time or Part time	Occupation:
DOB:	DOB:

Authorization & Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Date: _____

Signature of patient or parent if minor _____

Patient History Questionnaire

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough. Blue or black ink, only, please

NAME: _____ DOB: _____ AGE: _____

HT: _____ WT: _____ BMI: _____

REASON FOR SEEING THE DOCTOR: (Which surgery are you interested in?)

PLEASE LIST THE SURGERIES YOU HAVE HAD IN YOUR LIFETIME:

DO YOU CURRENTLY HAVE AN ABDOMINAL/INCISIONAL HERNIA? YES NO

MEDICATION ALLERGIES YES NO

Please list:

TAPE YES NO

LATEX ALLERGY YES NO

DO YOU TAKE ANY BLOOD THINNING MEDICATION SUCH AS COUMADIN, WARFARIN, ASPIRIN, OR PLAVIX? YES NO

DO YOU TAKE ANY NSAIDS (Non -steroidal anti inflammatory drugs) SUCH AS IBUPROFEN, MOTRIN , ALEVE , CELEBREX, NAPROSYN? YES NO

SOCIAL HISTORY: (Circle one)

Tobacco: YES NO How much _____ How Long _____ Quit _____

Alcohol: YES NO How much _____ How Long _____ Quit _____

Drug Use: YES NO How much _____ How Long _____ Quit _____

Birth Control: Pills Condoms Tubal Ligation Other: _____

PLEASE CHECK ALL THAT APPLY TO YOU

- HYPERTENSION (HIGH BLOOD PRESSURE)
- DIABETES MELLITUS
- SLEEP APNEA : Do you use CPAP or BI PAP ? Yes No
- HEART DISEASE
- LUNG DISEASE (COPD/Emphysema) Do you use Home Oxygen? Yes No
- PULMONARY EMBOLISM
- SHORTNESS OF BREATH AND EXERCISE INTOLERANCE DUE TO OBESITY
- ASTHMA
- BLOOD CLOTS
- BLOOD TRANSFUSION
- LIVER DISEASE (Hepatitis B, Hepatitis C)
- HIV/ AIDS
- KIDNEY DISEASE Are you on Dialysis? Yes No
- THYROID PROBLEMS
- LUPUS
- HEARTBURN/REFLUX
- STOMACH ULCER
- COLITIS
- CROHN'S DISEASE/ ULCERATIVE COLITIS
- HYPERCHOLESTEROLEMIA (ELEVATED CHOLESTEROL)
- HYPERTRIGLYCERIDEMIA (ELEVATED TRIGLYCERIDES)
- URINARY STRESS INCONTINENCE (WEAK BLADDER)
- CHRONIC BACK AND JOINT PAIN
- ARTHRITIS
- MIGRAINE HEADACHES
- EDEMA (LEG SWELLING)
- DEPRESSION / BIPOLAR DISORDER/ANXIETY
- FREQUENT PREDNISONE USE
- FAMILY HISTORY: OBESITY, DIABETES, HYPERTENSION, HEART DISEASE, CANCER



Dear Patient,

Please read this and sign below indicating that you understand the guidelines.

APPOINTMENT

- If you find that you are unable to keep your appointment, please call to cancel 24 hours in advance so that a time will be available for other patients.
- There will be a \$25.00 charge if 24 hours notice is not given for cancellations.

INSURANCE AND FEES

- I agree to pay for any and all medical services I receive from the doctor/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, plan does not pay for preventive medicine visits or my failure to secure a referral from my primary care physician) I will pay for the visit upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.
- There is a \$10.00 fee per form that must be paid in advance before we complete and/or return the form for Disability Insurance forms, Leave of Absence forms, and/or Return to work forms.

ACCOUNT BALANCES AND RETURNED BANK ITEMS

- Our office staff will always be glad to discuss fees with you. Should you have financial problems that result in the delay of payment, please contact the office manager and discuss the situation. We will not know you are having problems unless you tell us. We will make every effort to work out an acceptable payment plan to enable you to take care of your obligation.
- Patient account balances that exceed 60 days without payment will be turned over to our collection agency.
- We accept Cash, Check, Visa, MasterCard, and Care Credit or Money orders.
- If your check is returned from the bank, we will add the “returned fee” to your account in the amount of \$25.00.

I have read, understand, and agree to this Financial Policy. I understand the charges not covered by my insurance, as well as applicable co-payment and deductible are my responsibility.

Patient Signature

Date



I do hereby authorize Dr. David Kim, and those acting pursuant to its authority to:

I do hereby decline Dr. David Kim, and those acting pursuant to its authority to:

- a. Record my participation and appearance on video tape, audio tape, film, photograph or any other medium.
- b. Use my name, likeness, voice and biographical material in connection with these recordings.
- c. Exhibit or distribute such recording in whole or in part without restrictions or limitation for any educational or promotional purpose which Rosemont Media and those acting pursuant to its authority, deem appropriate.

Name: _____

Signature: _____

Date: _____

David D. Kim M.D.
35 Veranda Lane, Suite 100
Colleyville, TX 76034
Phone: (817) 581-6100
Fax: (817) 581-6127

NOTICE OF PRIVACY POLICIES AND PRACTICES
For
David D. Kim, M.D., F.A.C.S.

DEAR PATIENT:

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

INTRODUCTION

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit our office, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information; must be in writing
 - The right to receive confidential communications concerning your medical condition and treatment
 - The right to inspect and copy your protected health information
 - The right to amend or submit corrections to your protected health information
 - The right to receive a printed copy of this notice
-

OUR RESPONSIBILITIES

Our office is required to:

- Maintain the privacy of your health information
- We are required by law to provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction and acknowledge revisions with notifications
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations.

Any updates will be posted in our office. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of NHFP. For example: information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services to us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a collection agency, answering service and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment (ex: emergency situations) when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. We will ask patients 18 years and older to sign a consent to release information to anyone other than themselves.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. This practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail or a brief, non-specific message may be left on your answering machine / voicemail.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Dr. Kim, please contact:

PRIVACY OFFICE
35 Veranda Lane, Suite 100
Colleyville, TX 76034
817-581-6100

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D. C. 20201



I have received the information entitled
"Notice of Privacy Policies and Practices"

Name of Patient (Print)

Signature of Patient

Date

Signature of patient Representative

Relationship of Patient Representative to Patient

(PHI signature page)

Weight-Related History

Height	
Actual Body Weight	
Ideal Body Weight	
Excess Body Weight	
BMI	

Weight History

Please list your average weight over the last 5 years

Year	Age	Weight

Weight Loss History

Supervised weight loss attempts

Diet Attempted	Duration Mo/Yr—Mo/Yr	Method Used	Duration Mo/Yr ---Mo/Yr
<i>Home Gym Equipment</i>		<i>Acupuncture</i>	
<i>Gym Membership</i>		<i>Diet pills from MD</i>	
<i>Health Spa</i>		<i>Diet shots from MD</i>	
<i>Calorie counting</i>		<i>Diet Center</i>	
<i>High Protein</i>		<i>Jenny Craig</i>	
<i>Low Carb</i>		<i>Overeaters Anonymous</i>	
<i>Low fat</i>		<i>Optifast /Medifast</i>	
<i>Hypnosis</i>		<i>LA weight loss</i>	
<i>Atkins Diet</i>		<i>Nutri system</i>	
<i>Mayo Clinic Diet</i>		<i>Psychological Counseling</i>	
<i>Richard Simons</i>		<i>Supervised Calorie Counting</i>	
<i>Scarsdale diet</i>		<i>T.O.P.S</i>	
<i>Sugar Busters</i>		<i>Weight Watchers</i>	
<i>SlimFast</i>		<i>Harris fast</i>	
<i>South Beach Diet</i>			
<i>Other:</i>			
<i>Other:</i>			

Weight Loss medications

	Medication	Duration Mo/Yr-Mo/Yr	Physician supervised Yes No
	<i>Acutrim OTC</i>		
	<i>Adipex</i>		
	<i>Amphetamines</i>		
	<i>Dexatrim OTC</i>		
	<i>Fastin</i>		
	<i>Herbal Remedies OTC</i>		
	<i>Ionamin</i>		
	<i>Meridia</i>		
	<i>Metabolife OTC</i>		
	<i>Phentermine</i>		
	<i>Pondimin</i>		
	<i>Phen fen</i>		
	<i>Redux</i>		
	<i>Tenuate</i>		
	<i>Trimspa OTC</i>		
	<i>Xenical</i>		
	<i>Zenadrine OTC</i>		

Level of Activity

Activity	Duration	Frequency	Limitations: shortness of breath/pain
<i>Aerobics-land</i>			
<i>Aerobics -water</i>			
<i>Biking</i>			
<i>Organized exercise</i>			
<i>Stairs</i>			
<i>Swimming</i>			
<i>Walking</i>			
Daily use of walking aids? <i>Circle all that apply</i>			
Cane	Walker	Wheelchair	Motorized cart

Do you have/have you had trouble sleeping?

- No
- Yes

- Morning headache
- Daytime drowsiness
- Restless sleep
- Snoring
- Waking up at night

Number of naps/day: _____

Do you feel rested when you wake up in the morning?

- No
- Yes

Have you ever fallen asleep at the wheel?

- No
- Yes

Do you ever wake up from a deep sleep choking or coughing?

- No
- Yes

Has anyone ever told you that you stop breathing while you sleep (an observed apnea)?

- No
- Yes

Have you ever had a sleep study?

- No
- Yes Date: _____

Did you have sleep apnea?

- No
- Yes

If you have sleep apnea, do you use a:

- BiPap
- CPAP

SLEEPINESS SCALE	
0=no chance of dozing 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (meeting, theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Emotional/Psychological Evaluation

*Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, use the scale below to describe **HOW MUCH** that problem has **BOTHERED** or **DISTRESSED** you during the past week, including today*

Not at All	A little Bit	Moderately	Quite a bit	Extremely
0	1	2	3	4

- _____ 1. Nervousness or shakiness inside
- _____ 2. Unwanted thoughts, words, or ideas that won't leave your mind
- _____ 3. The idea that someone else can control your thoughts
- _____ 4. Feeling others are to blame for most of your troubles
- _____ 5. Trouble remembering things
- _____ 6. Feeling easily annoyed or irritated
- _____ 7. Feeling afraid in open spaces or on the street
- _____ 8. Thought of ending your life
- _____ 9. Hearing voices that other people do not hear
- _____ 10. Feeling that most people cannot be trusted
- _____ 11. Crying easily
- _____ 12. Feeling of being trapped or caught
- _____ 13. Suddenly scared for no reason
- _____ 14. Temper outbursts that you could not control
- _____ 15. Feeling afraid to go out of your house alone
- _____ 16. Feeling blue
- _____ 17. Worrying too much about things
- _____ 18. Feeling fearful
- _____ 19. Other people being aware of your private thoughts
- _____ 20. Having to avoid certain things, places, or activities because they frighten you
- _____ 21. Your mind going blank
- _____ 22. Feeling hopeless about the future
- _____ 23. Trouble concentrating
- _____ 24. Having thoughts that are not your own
- _____ 25. Having urges to beat, injure, or harm someone
- _____ 26. Having urges to break or smash things
- _____ 27. Having ideas or beliefs that others do not share
- _____ 28. Spells of terror and panic
- _____ 29. Getting into frequent arguments
- _____ 30. Feeling nervous when you are left alone
- _____ 31. Feeling so restless you couldn't sit still
- _____ 32. Feelings of worthlessness
- _____ 33. Feeling that familiar things are strange or unreal
- _____ 34. Shouting or throwing things
- _____ 35. Thoughts of suicide
- _____ 36. The idea that you should be punished for your sins
- _____ 37. The idea that something is wrong with your mind
- _____ 38. Feeling afraid to travel on buses, subways or trains

MEDICATIONS

Please list ALL medications you are currently taking: this includes over-the-counter products, prescription medications and any herbal supplements/vitamins you use.

NAME	DOSE	HOW OFTEN	REASON

Physician List

Please list the names, addresses and phone numbers of ALL the doctors you are currently seeing (including PCP, heart doctor, psychiatrist, therapist, dietitian, etc); if you do not know the address (including ZIP code), please call the office and obtain a complete mailing address. If not enough space is provided, feel free to complete the list on the back of this form.

Name	Specialty	Phone	Fax	Mailing Address

Initials

_____ I have answered the above questions of this document truthfully to the best of my ability.

_____ I () am or () am not willing to comply with pre-operative and post-operative treatment plans to include dietary restrictions and monthly support group attendance.

_____ I () do or () do not understand that the ultimate decision regarding the bariatric surgery that is performed will be a decision based on discussion with Dr. Kim at the time of my preoperative appointment with him after my insurance predetermination is made.

Patient's Signature

Initials

Date

Time

Authorization for Use and Disclosure of Protected Health Information (PHI)

Dr. David Kim
35 Veranda Lane, Suite 100
Colleyville, Texas 76034
Phone 817-581-6100 Fax 817-581-6127

Patient Name: _____
Date of Birth _____ Social Security Number: _____
Address: _____ Telephone: _____
City: _____ State: _____ Zip code: _____

I authorize: _____
(Patient's physician) or Facility

to disclose my medical record information and /or protected health information to:

Dr. David Kim
35 Veranda Lane, Suite 100
Colleyville, TX 76034
Please fax to 817-581-6127

for the purpose of Bariatric Surgery.

I authorize: **Dr. David Kim and /or Live Life Again Bariatric Surgery Center**
To disclose my medical record information and /or protected health information to:

To my insurance company: _____

For the purpose of Bariatric Surgery.

Type of Access Requested:

- ___ 1. Letter of Medical Necessity and medical clearance for surgery.
- ___ 2. Progress Notes: _____
- ___ 3. Lab work
- ___ 4. Weight history (one progress note per year X 5 years of documented weight)
- ___ 5. Medication Record
- ___ 6. Other _____

_____ I acknowledge, and hereby consent to such, that the released information may contain
Initials alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization maybe subject to re-disclosure by the recipient and no longer protected.

Fees/charges will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ Date _____ Signature of Patient