Office Locations

Newark
537 Stanton-Christiana Road
Suite 102
Newark, DE 19713
Office Hours: Monday-Friday 8:00 am to 4:00 pm

North Wilmington
Concord Plaza Office
3521 Silverside Road
Quillen Bldg, Suite 1G
Wilmington, DE 19810
Office Hours: Days & Hours vary.

Dover
1102 S. DuPont Highway
Suite 1
Dover, DE 19901
Office Hours: Tuesday, Wednesday, Thursday. Hours vary.

Websites:
www.chrias.com
www.balloonprocedure.org
www.vbloc.com
www.aspirebariatrics.com

Phone number:
302-892-9900

Fax number:
302-892-9980

Dear Patient,

Thank you for choosing CHRIAS and the Weight Loss Center of Delaware! We are pleased you have chosen our physicians for your surgery.

We do accept and bill all insurance companies; however, it is possible we may not be "in-network" with your particular carrier. Prior to your appointment, you should check with your insurance company whether or not your initial consultation is an "in-network" benefit.

If it is, you will want to verify if a referral is required and obtain one. Please bring this referral and your insurance card with you to your consultation; otherwise you will be required to pay a consultation charge of $300 for your visit before you are seen.

The new patient packet, which accompanies this letter, contains several documents:

- A registration form requesting demographic and billing information from you,
- Our appointment cancellation policy,
- An authorization form which gives us permission to disclose Personal Health Information to appropriate parties, such as your primary care doctor,
- The patient questionnaire.

It is important you complete and sign each document and bring it with you to the seminar, along with a photocopy of the front and back of your insurance card. You may fax, mail, or drop off your complete packet. Our fax number is **302-892-9980**.

You may print directions to any of our offices from our website. Go to www.chrias.com, click on "CHRIAS Hospitals and Locations", then click on the specific location's map.

If you have any questions, please call our office at 302-892-9900.

Thank you,
Christiana Institute of Advanced Surgery
Weight Loss Center of Delaware

Office Registration Form

Name:			**Date of Birth:**
Address:		**City:**	**Zip:**
Home Phone #:	**Work Phone #:**	**Cell Phone #:**	**Gender (circle):** Male Female
Soc. Security #:	**Race (Circle):** American Indian | Asian Native |Hawaiian | Black or African American | White | Hispanic | Other		**Ethnicity (circle):** Hispanic | Non-Hispanic
Marital Status ***(S-Single, M-Married, D-Divorced, W-Widowed)*****:**	**Email Address:**		
Employer:	**Employer Phone#:**	**Occupation:**	

Chief Complaint/Reason for Visit: _____

Name of Primary Care Physician:_____Phone #:_____

Who Referred You to Us? *(Check all that apply & specify)*

□**Physician (Name)** _____ □**Internet/Website** _____

□**Friend/Relative (Name)** _____ □**Advertising** _____

□Other _____

Participating Pharmacy: _____Phone #:_____
Emergency Contact: _____Relation:_____
Phone#:_____

Primary Insurance: _____ Policy ID #:_____
Policy Holder's Name: _____
Date of Birth:_____
Secondary Insurance:_____ Policy ID #:_____
Policy Holder's Name: _____
Date of Birth:_____

Initial: **_____ I agree to bring my insurance card and co-pay (if applicable) to *every* appointment. I am aware that if I do not, my appointment may need to be cancelled and rescheduled.**

Please initial:

_____I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by my physician. I understand and agree I will be responsible for any charges, i.e. co-payments, deductibles, or non-covered services not paid for by my insurance carrier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services rendered.

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may call my home or other designated location and leave message on my voice mail or with a person listed above in reference to any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may mail to my home or other designated location any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA restricts how it uses or discloses my PHI to carry out the TPO, However, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA has already made disclosure in reliance upon my prior consent. If I do not sign this consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may decline to provide services to me.

Signed by: _____ _____

Signature of Patient Date

_____

Patient's Name

(PATIENT WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

Name:_____ DOB:_____

No Show/ Cancellation Policy

Attention CHRIAS Patients:

We understand that there are times when you must miss an appointment due to emergencies, unforeseen events or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. Conversely, a situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

Patients who No Show two or more times within a 12-month period will receive a No Show letter emphasizing the importance keeping scheduled visits and the ramifications of failing to keep future appointments. Patients who continue to No Show after receiving the No Show letter are subject to be discharged from the practice and will not be eligible to schedule future visits.

We ask that you are mindful of other patients' time by providing us 48 hours' notice when cancelling an office appointment.

Appointment Type	Minimum Timeframe to Cancel	Charge
New Patient	48 hours	$100.00
Established Patient	48 hours	$25.00
Surgical Procedures	2 weeks	$100.00

Patients with Medicaid are excluded from the aforementioned; however the "No Show" will be documented with their insurance company. ***Both the Cancellation and No Show fees are the patient's sole responsibility and must be paid in full before the next appointment.***

Insurance Coverage Awareness Policy

As a patient of CHRIAS, it is my responsibility to confirm that I have Bariatric Surgery Benefits with my insurance carrier prior to starting the bariatric process.

Please sign below acknowledging that you have read, understand and agree to the Cancellation/No Show and Insurance Coverage Awareness terms above.

Patient Name **Date of Birth**

Patient Signature **Date**

Name:_____ DOB:_____

Disability Form/FMLA Request

Name: _____ Date: _____

Dear Patient,

If you require disability forms to be completed prior to your scheduled surgery, our office needs a signed release and processing fee of $20.00. A minimum of **seven to ten** business days are required for completion. There is no charge to complete and FMLA form.

Thank you in advance for following these simple directions. It will enable our office to process your request more efficiently. Completed forms may be picked up or faxed. If you have any questions, please call our office at (302) 892-9900.

Sincerely,

Natalia Co

Natalia Co
Practice Administrator

_____ _____
Patient Signature Date

Name:_____ DOB:_____

Patient Questionnaire

The following information is very important to your health. Please take time to fill this information out completely and to the best of your ability. ***Use black or blue ink only, please!***

Weight History

	Age	Weight
At the start of high school		
At high school graduation		
When you got married		
Lowest weight last 5 years		
Highest weight last 5 years		
Current Weight		

Current Height: _____

For Females

	Age	Weight
Start of pregnancy 1		
Start of pregnancy 2		
Start of pregnancy 3		

Is there any reason you cannot receive a blood transfusion? □ Yes □ No
Explain: _____

_____

Neurologic

	Yes	No
Have you ever fainted?		
Had a convulsion?		
Experience double vision		
Ringing in ears		
Severe headaches		
Weakness in arms or legs		
Visual disturbances		
Pain on one side of the head		
Do you have headaches that awaken you at night?		
What relieves them?		

Name:_____ DOB:_____

Cardiac

	Yes	No
Chest pain/tightness with exertion		
Chest pain/tightness at rest		
Varicose veins		
Edema (ankle swelling)		
Scaly, thick skin in legs		
Leg ulcers		
Phlebitis		

Musculoskeletal

	Yes	No
Pain in calves while walking		
Pain in big toe		
Back problems		
Cramps in legs at night		
Joint pain or arthritis		
Pain in hips/knees/ankles/feet		
Difficulty walking		

If yes, have you been seen by a:

Chiropractor □ Yes □ No Orthopedic Surgeon □ Yes □ No

Primary Care Physician □ Yes □ No

Genitourinary

	Yes	No
Burning with urination		
Loss of bladder control		
Urine leaking when laughing or coughing		
Blood in urine		
Passed a kidney stone		
Dark-colored urine		
Trouble starting urination		
Trouble holding urine		
Frequency/awakening at night		

Psychiatric

	Yes	No
History of psychiatric illness		
Suicide attempts		
Bipolar or manic depression		
Depression		
Obsessive Compulsive Disorder		
Anxiety/panic attacks		

Please list any psychiatric hospitalizations:

Date	Reason

Previous Weight Loss Attempts

Have you discussed your weight problem with your doctor in the past two years? □ Yes □ No

Did your doctor recommend bariatric surgery? □ Yes □ No

Doctors who helped me lose weight:

Name	Year	Wt. Lost	Wt. Gained	How Long?

Name:_____ DOB:_____

Please fill out any of the weight loss programs you have attempted in the past:

	Weight Watchers	Jenny Craig	Atkins	Exercise/Walking	Low Carb	South Beach	Low Fat	Nutrisystem	Nutritionist	Opti-fast	Phenfen	Slim Fast
Year												
Weight Lost												
Weight Regained												
Length of Program												
Did Your Physician Know?												

Eating Behavior

Check all that apply:

□ Large portions□ Eat fast □ Difficulty chewing□ Always hungry□ Fast food frequently
□ Never hungry□ Eat secretly□ Binge□ Eat chips/pretzels □ Frequent snacking
□ Enjoy sweets□ Enjoy soda□ Skip meals□ Eat past satisfaction

Weight-Related Illnesses

Please answer if you currently have, or ever had, any of the following:

1. **High Blood Pressure** □ Yes □ No
   Year Diagnosed:_____

   Medications:_____

2. **Heart Disease** □ Yes □ No
   Year Diagnosed:_____
   Have you had any of the following (circle all that apply):
   Abnormal EKG
   Palpitations
   Stress test Date of last stress test:_____

3. **Sleep Apnea** □ Yes □ No
   Year Diagnosed:_____
   CPAP/BiPAP usage: □ Yes □ No If yes, onset date:_____

4. **Diabetes** □ Yes □ No
   Year Diagnosed:_____

5. **Reflux/GERD** □ Yes □ No
   Year Diagnosed:_____

6. **High Cholesterol** □ Yes □ No
   Year Diagnosed:_____ Medications:_____

Name:_____ DOB:_____

Gastrointestinal

Have/Do you have stomach pain which:

	Yes	No
Occurs 1-2 hours after meals		
Is precipitated by fried/greasy food		
Is relieved by antacids		
Is relieved by bowel movement		
Awakens you at night		
Is relieved by eating		
Occurs while eating		
Causes constipation		

Do you have:

	Yes	No
Abdominal cramps		
Alternating diarrhea		
Black stools		
Blood in stools		

Women (only)

Do you still have menstrual periods? □ Yes □ No
If yes, check off any applicable:
heavy _____painful _____irregular_____
Date of last period:_____
Any bleeding between periods? □ Yes □ No
List method(s) of birth control:_____
_____

Do you plan a pregnancy within 2 years? □ Yes □ No
List date of last PAP test: _____
List date of last mammogram: _____
Number of:
Pregnancies_____ Live births_____ Miscarriages_____ Still births_____
Caesarean sections_____ Premature births_____
Complications of pregnancies: _____
_____

Men (only)

Do you have a history of:

Hernia □ Yes □ No
Prostate problems □ Yes □ No
Loss of sexual Function □ Yes □ No
Other □ Yes □ No

If other, describe in detail:_____
_____

Name:_____ DOB:_____

Family History

	Mother	Father	Siblings	Children
Obesity				
Diabetes				
Cardiovascular Disease				
Heart Attack				
Cancer				
Blood Clots to Legs or Lungs				
High Blood Pressure				
Sleep Apnea				
Early Death & Cause				
Anesthesia Problems				

Past Medical/Surgical History

□Weight loss surgery
□C-section
□Gall bladder removed (Laparoscopic? _____)
□Hernia repaired
□Surgery on colon
□Colonoscopy What year?_____ Findings_____
□Surgery for reflux
□Surgery for adhesions
□Surgery to remove small intestine
□Groin hernia repaired
□Other_____

Describe illnesses that did not require hospitalization; list all health conditions for which you are currently receiving care, e.g. diabetes, sleep apnea, high blood pressure, etc.

_____
_____
_____

List all hospitalizations in last 5 years — Please include the reason and date:

_____
_____
_____
_____
_____

Please check off any of the following symptoms you have experienced:

□ Heart attack
□ Elevated blood sugar
□ Frequent boils/skin infections
□ Racing heart/skipped beats
□ Shortness of breath
□ Diabetes while pregnant
□ Thyroid problems
□ Asthma
□ Blood clots in lungs
□ Pneumonia
□ Snoring
□ Blood clots in legs
□ Restless sleep/difficulty sleeping
□ Wake up gasping for breath
□ Heartburn
□ Swelling in legs
□ Kidney problems
□ Diarrhea
□ Problems conceiving/infertility
□ Abnormal pain
□ Problems with gallbladder

Name:_____ DOB:_____

Allergies

List all Allergies, including latex, drugs, environmental, food and other.

Allergy	Reaction Experienced

Medications

Please list all medications (prescription or over-the-counter):

Medication	Dosage	Schedule

Name:_____ DOB:_____

General Knowledge of Procedure

Please rank your knowledge of the following topics related to the procedure by checking in the appropriate box:

G=Good **A=Adequate** **P=Poor**

	Gastric Bypass			Gastric Sleeve			Gastric Banding		
	G	A	P	G	A	P	G	A	P
Staples									
Pouch size									
Laparoscopy									
Restricted intake									
Malabsorbtion & vitamins									
Medical follow-up									
Food restrictions									
Behavior changes									

Please check off to indicate your understanding & knowledge of the risks that may be associated with these procedures ***(G = Good; A = Adequate; P = Poor):***

	Gastric Bypass			Gastric Sleeve			Gastric Banding		
	G	A	P	G	A	P	G	A	P
Death									
Obstruction									
Stricture									
Leakage									
Blood clots									
Ulcers									
Pneumonia									
Infection(s)									
GERD									
Gallstones									
Hair loss									
Lactose intolerance									
Dumping Syndrome									
Psychological changes									
Indequate or excessive weight loss									
Vitamin & mineral deficiencies									

What is your expected loss at four months post procedure? _____
What is your expected loss at one year post procedure? _____

Motivation

Please write a short statement of why you want this surgery and how you think the surgery may help you.

_____

_____

_____

Coping and Compliance

Please list specifically the ways in which you have demonstrated compliance with medical instruction in the past.

_____

_____

_____

_____

Describe your support systems, listing the people that will be involved in your procedure:

_____

_____

_____

_____

Is anyone being purposefully excluded? □ Yes □ No
If yes, describe:_____

_____ _____

_____

Physical Exercise Programs/Exercises

Program/type	Time spent	Weight lost	Weight regained	Estimated length of program	Estimated expense of program
Bicycle					
Jogging					
Swimming					
Gym membership					
Aerobic exercise					
Video tape exercises					
Home gym					
Personal trainer					
Other—Name					

The above is true to the best of my belief.

Please sign below:

_____ _____

Signature Date

Name:_____ DOB:_____

Welcome to Your Secure Patient Portal – IQ HEALTH!

Dear Patient,

In order to effectively communicate with your physician and the CHRIAS staff, **you must** sign up for our secure patient portal called **IQHealth!**

This system allows web based interactions between patients and our office. You will be able to:

- ✓ Review your test results
- ✓ Access your medical records
- ✓ Request an appointment
- ✓ Request medication refills
- ✓ Update demographic information
- ✓ Communicate electronically and securely with your doctor
- ✓ Receive paperless billing and track your payments

In order to take advantage of this new feature, you will need an online invitation. To set up your account, you will receive a one-time secure email invitation from **IQHealth.com** with the subject "**United Medical Physicians invites you to join IQ Health"**.

Please check your email Inbox and/or Spam folder and expect to see the invitation within 1-2 business days. Simply click on the link in your email and follow the prompts to activate your account. This link will expire in 30 days. For any questions or concerns please contact the office for assistance at (302) 892-9900.

We hope this new system will make communication with our office easier and more convenient.

Sincerely,

Christiana Institute of Advanced Surgery

Website: IQHealth.com **Smartphone App: HealtheLife**

"I wish to participate" (**please print clearly**)

Name: _____ Date of Birth: _____

Email Address: _____ Last 4 digits of SSN: _____

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA

Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with their requested records.

PATIENT INFORMATION (Please Print)				
✓ Patient Name		✓ Date of Birth / /		Social Security Number _____ - _____ - _____
✓ Address	City	State	Zip	✓ Phone

RELEASE FROM (Name of Physician or Facility)				
I authorize release of my medical records from:				
Address	*City*	*State*	*Zip*	*Phone* / *Fax*

RELEASE TO (Name of Physician or Facility Receiving Information)				
Please send my medical records to: Physician / Facility	Christiana Institute of Advanced Surgery			
537 STANTON-CHRISTIANA RD, SUITE 102 Address	NEWARK City	DE State	19713 Zip	✓ Phone 302-892-9900 ✓ Fax 302-892-9980

RELEASE INFORMATION

✓ Reason:	☐ Change of Insurance ☐ Moving Out-Of-Area	☐ Transfer of Care ☐ Specialist Consultation	☐ Personal File ☐ Legal

✓ Please release the following (check all that apply)

☐ Recent H & P	☐ Hospital Reports	☐ X-Ray Reports
☐ Lab Reports	☐ Last Three (3) Visits	☐ Others:

Please allow 15 days for processing. Incomplete information will delay processing.
Use of this information for any other than the stated purpose is prohibited.
This information is for the use of designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test result	☐ YES	☐ NO
I understand that I may be charged for copies provided	☐ YES	☐ NO

✓ _____ ✓ _____

Signature of patient, parent, guardian, conservator, or patient representative (circle one) Date

✓ _____ _____

Witnessed by: Date

Note: *This consent is valid for 90 days. It may be revoked by the signer at any time.*

For Office Use:

Released/ Mailed/Faxed:	Received By:
Initial/Date:	Signature/Date:

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA

Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with their requested records.

PATIENT INFORMATION (Please Print)

✓ Patient Name		✓ Date of Birth / /		Social Security Number ___-___-___
✓ Address	City	State	Zip	✓Phone

RELEASE FROM (Name of Physician or Facility)

I authorize release of my medical records from: **Christiana Institute of Advanced Surgery**

537 STANTON-CHRISTIANA RD, SUITE 102	NEWARK	DE	19713	*Phone* 302-892-9900
Address	*City*	*State*	*Zip*	*Fax* 302-892-9980

RELEASE TO (Name of Physician or Facility Receiving Information)

Please send my medical records to:
Physician / Facility

Address	City	State	Zip	✓Phone ✓Fax

RELEASE INFORMATION

✓Reason:	☐ Change of Insurance ☐ Moving Out-Of-Area	☐ Transfer of Care ☐ Specialist Consultation	☐ Personal File ☐ Legal

✓Please release the following (check all that apply)

☐ Recent H & P ☐ Hospital Reports ☐ X-Ray Reports
☐ Lab Reports ☐ Last Three (3) Visits ☐ Others:

Please allow 15 days for processing. Incomplete information will delay processing.
Use of this information for any other than the stated purpose is prohibited.
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I authorize the release of HIV/HTLV/AIDS test result	☐ YES	☐ NO
I understand that I may be charged for copies provided	☐ YES	☐ NO

✓_____ ✓_____
Signature of patient, parent, guardian, conservator, or patient representative (circle one) Date

✓_____ _____
Witnessed by: Date

Note: *This consent is valid for 90 days. It may be revoked by the signer at any time.*

For Office Use:

Released/ Mailed/Faxed:	Received By:
Initial/Date:	Signature/Date: