NORTH CAROLINA SURGERY
UNC HEALTH CARE

Check list prior to first Orientation/Nutrition Class

Plan to arrive on time for your scheduled class. **Those who arrive 15 minutes past the start time of the class will not be allowed to enter the classroom.** Orientation/Nutrition classes are held only on Wednesdays with arrival times at either 7:45am or 10:15am. The class will last approximately 2 hours. Please allow extra travel time due to high traffic volumes.

What to Bring to Orientation/Nutrition class:

- Photo ID
- Insurance Card(s)
- Completed paperwork from the folder you received at the information seminar or the paperwork that was mailed to you after scheduling your appointment. There is extensive paperwork to be completed. **You will be asked to reschedule if you arrive without completed paperwork.**

What to do before your Orientation/Nutrition class:

1. Confirm with your insurance that you have bariatric surgery, nutrition and mental health coverage. The following are codes that you can give to the insurance company to confirm your coverage:

- **Diagnosis Code E66.01 - Obesity**
- **43644**-Laparoscopic Roux-En-Y Gastric Bypass
- **43775**-Laparoscopic Gastric Sleeve
- **43659**-Laparoscopic Duodenal Switch-Some insurances will not cover this surgery unless your BMI is 50 or above.
- **97804**-Group nutrition classes/**97803**-One on one nutrition sessions
- **90791** – Office visit with Psychologist

2. Please try to bring any of the following information with you to your first appointment:

- Any lab work that was done within the last 2 months.
- Any Gastroenterology studies such as an Upper Endoscopy, Upper GI study, or a colonoscopy that was done within the last 2 years.
- Any previous sleep study reports done within the last 5 years.
- Cardiologist information
- Gallbladder Ultrasound-Any gallbladder ultrasound that has been done in the last 2 years.

3. Financial Information:

- Co-pays are due at the time of service and will be collected at check-in.
- If you have an insurance plan that requires a referral from your primary care physician before being seen, then the patient will be responsible for obtaining this referral. You will be considered self-pay without this referral.
- All account balances, remaining deductible, and co-insurance amounts will need to be paid in full prior to scheduling surgery.
- Medicare patients will also need to read the Medicare information handout.

North Carolina Surgery

PATIENT IDENTIFICATION

Patient's Legal Name _____
(LAST) (FIRST) (MIDDLE)

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Gender ____ Last 4 numbers Social Security# (some insurances require full SS) _____

Birth Date _____

PATIENT INFORMATION: Race_____Hispanic_____Non-Hispanic_____Language_____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Mobile Phone #_____Email Address_____

Referring Physician _____

Primary Care Physician_____

Other Physicians to Whom You Want Communication Sent _____ _____

PATIENT EMPLOYMENT INFORMATION

Status: Full-time ___ Part-time ____ Retired ____ Retirement Date _____ Full Time Student? Y/N Other_____

Employer's Name _____ Phone # _____

GUARANTOR INFORMATION (Person Financially Responsible if different than patient)

Name of Guarantor _____ Relationship to Patient _____

Last 4 Digits of Social Security # _____ Gender _____ Birth Date _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Employer's Name _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Work Phone # _____Cell Phone # _____

PRIMARY INSURANCE

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

SECONDARY INSURANCE

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) _____ Description_____

Accident Date and Time _____Place of Accident (City,County,State)_____

Patient/Authorized Representative Signature _____Date_____

UNC HEALTH CARE

Patient Name_____
Date of Birth_____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.[1] I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

_____DATE: _____ TIME:_____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

Chart Location: Consents

UNC HEALTH CARE

Patient Label Here

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 6)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health Care) is an integrated health system made up of various entities, including (but not necessarily limited to) UNC Hospitals; Rex Hospital, Inc.; Caldwell Memorial Hospital, Incorporated; Chatham Hospital, Inc.; Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital; the University of North Carolina at Chapel Hill, School of Medicine; Johnston Health Services Corporation; Nash Hospitals, Inc.; Nash MSO, Inc.; NHCS Physicians, Inc. ; UNC Rockingham Health Care, Inc.; Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ; Wayne MRI, LLC; UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC (each referred to in this form as a "UNC Health Care affiliate" or collectively as "UNC Health Care affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health Care affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health Care affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health Care affiliates but are authorized by UNC Health Care affiliates to provide treatment and care to me as a patient of the UNC Health Care affiliate. I am aware that the providers listed on Exhibit A to this consent are independent contractors of UNC Health Care affiliates, as listed, and they provide services to the UNC Health Care affiliate's patients in accordance with their professional judgment. The providers listed on Exhibit A are not employees or agents of the UNC Health Care affiliate. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at UNC Health Care affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health Care affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of the UNC Health Care affiliate or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

For more detailed information about the way my information may be used or released, I can read UNC Health Care's *Notice of Privacy Practices*.

I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care

I further give permission to UNC Health Care affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a

particular UNC Health Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

I further authorize release of financial information and activity related to payment for services to:

Name of Individual: _____

Relationship to Patient: _____

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health Care affiliate on my behalf. I authorize UNC Health Care affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health Care affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health Care affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care affiliate's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke this consent at any time by calling or writing to UNC Health Care.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health Care affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health Care affiliates from all liability for the loss or theft of, or damage to, such belongings.

Patient List

As a convenience to patients and visitors, UNC Health Care affiliates may keep a list of patients currently receiving services at a facility so that they may provide the location of the patient in the facility and the patient's general condition to people who ask for patients by name. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my location and general condition to individuals who ask for me by name.

_____ *(initial)* I do not want to be included in UNC Health Care affiliates' patient lists. Please remove my name.

Religious Information

UNC Health Care affiliates may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my name, location, general condition, and religious affiliation to community clergy who request it.

_____ *(initial*) I do not want to be included in UNC Health Care affiliates' list provided for clergy. Please remove my name. I understand that those employed by a UNC Health Care affiliate as chaplains may still obtain this information.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family and friends under the following conditions: (1) the information is related to that individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition or death. Unless I have initialed below, I give permission for limited health information to be shared with my family and friends under the conditions mentioned above.

_____ *(initial)* I do not want personal health information shared with family or friends.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____ DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

_____
PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay**.

_____ DATE: _____ TIME: _____
GUARANTOR OF PAYMENT SIGNATURE

_____
PRINTED NAME

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals ("UNCH")
I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals' patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. ("Rex")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, psychiatrists, OB hospitalists; radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

Caldwell Memorial Hospital, Incorporated ("Caldwell")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. ("Chatham")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee")
I am aware that the radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation ("Johnston")
I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. ("Nash")
I am aware that all the physicians who practice at Nash and may treat me, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, medical and radiation oncologists, EKG readers, hospitalists (including primary care hospitalists, pediatric hospitalists, neonatologists and surgicalists), bariatric surgeons, cardiologists, psychiatrists, wound care physicians, and their respective nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ("Wayne")
I am aware that the radiologists, pathologists, anesthesiologists, emergency room physicians, surgeons, psychiatrists, internists, nephrologists, oncologists, EKG readers, cardiologists, wound care physicians, intensivists, hospitalists and any other independent physician and their nurse practitioners and physician assistants, are independent contractors who provide services to Wayne's patients in accordance with their professional judgment. These practitioners are not employees or agents of Wayne.

Wayne MRI, LLC ("Wayne MRI")
I am aware that the radiologists at Wayne MRI are independent contractors who provide services to Wayne MRI in accordance with their professional judgment. These practitioners are not employees or agents of Wayne MRI.

UNC Rockingham Health Care, Inc. ("Rockingham")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rockingham patients in accordance with their professional judgment. These practitioners are not employees or agents of Rockingham.

EXHIBIT B

NOTICE OF NONDISCRIMINATION

UNC Health Care and its affiliated Network Entities comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. UNC Health Care and its affiliated Network Entities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

A. Free Aids and Services

UNC Health Care and its affiliated Network Entities:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need to receive these services, contact the individual identified below (Section C), for the Network Entity location where you are receiving services.

B. Grievances

If you believe that UNC Health Care or an affiliated Network Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the following individuals (Section C), depending on where you are receiving services. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the individual identified below, for the Network Entity location where you are receiving services, is available to help you.

C. Contacts

Network Entity	Person to Assist with Free Aids and Services	Person to Assist with Grievances
UNC Medical Center (UNC Hospitals; UNC Faculty Physicians; UNC Health Care Shared Services Pharmacy; UNC Homecare; and UNC Home Health)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu
Caldwell Memorial Hospital, Inc.	Patient Care Coordinator 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5100	Risk & Regulatory Department 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5555 E-mail: RiskMgtUNCCaldwell@unchealth.unc.edu
Chatham Hospital, Inc. and **Chatham Imaging Services of Pittsboro, LLC**	Interpreting Services Director 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4770	Director of Quality and Risk Management 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4015
Johnston Health Services Corp. (d/b/a **Johnston Health**)	Telephone Operator 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: (919) 934-8171	Compliance Director 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: 919-938-7121
Henderson County Hospital Corp. (d/b/a **Margaret R. Pardee Memorial Hospital**)	Interpreter Services 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 696-4644	Civil Rights Coordinator 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7998
Nash Health Care Systems (Nash Hospitals, Inc.; Nash MSO, Inc.; and NHCS Physicians, Inc.)	Community Outreach/Emergency Management Coordinator 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-3461	Coordinator for Quality Support Services & Risk Management 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-8767
UNC REX Healthcare (Rex Hospital, Inc.; Rex Surgery Center of Wakefield, LLC; Rex Surgery Center of Cary, LLC; Rex Wakefield Wellness, LLC; and Rex Radiation Oncology, LLC)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Quality Programs 4420 Lake Boone Trail Raleigh, NC 27607 Phone: (919) 784-3429
UNC Rockingham Health Care, Inc.	Administrative Supervisor 117 East Kings Highway Eden, NC 27288 Phone: (336) 520-7592 ext. 1712229	Director of Quality and Risk Management 117 East Kings Highway Eden, NC 27288 Phone: (336) 627-4212

UNC Physicians Network, LLC; and **UNC Physicians Network Group Practices, LLC**	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Human Resources Executive 2000 Perimeter Park Drive Suite 200 Morrisville, NC 27560 Phone: (984) 215-4032 E-mail: contactuncpn@unchealth.unc.edu
Wayne Memorial Hospital, Inc. (d/b/a Wayne UNC Health Care) (Wayne MRI, LLC)	Patient Care Coordination Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 731-6407	Patient Experience Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 587-2273 Email: patient.experience@waynehealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

D. Attention

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電：
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 연락처:
- ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। इस पर कॉल करें:
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:
- સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો:
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:
- Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ́-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá:
- గమనిక: మీరు తెలుగు భాషను మాట్లాడేవారు అయితే, భాష సహాయక సేవలు మీకు ఎటువంటి ఛార్జీలు లేకుండా ఉచితంగా అందుబాటులో ఉన్నాయి. ఈ నంబర్‌కు కాల్ చేయండి:
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:
- ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

UNC Medical Center (UNC Hospitals, UNC Faculty Physicians, UNC Shared Services Center Pharmacy, UNC Homecare, and UNC Home Health):

1-984-974-5006

Caldwell Memorial Hospital:

1-828-757-5100

Chatham Hospital and Chatham Imaging Services of Pittsboro:

1-984-974-5006

UNC REX Healthcare (Rex Hospital; Rex Surgery Center of Wakefield; Rex Surgery Center of Cary; Rex Wakefield Wellness; and Rex Radiation Oncology):

1-984-974-5006

Johnston Health:

1-919-934-8171

Margaret R. Pardee Memorial Hospital:

1-828-696-4644

Nash Health Care Systems (Nash Hospitals, Nash MSO, and NHCS Physicians):

1-252-962-8000

UNC Rockingham Health Care

1-336-520-7592 ext. 1712229

Wayne Memorial Hospital (Wayne MRI, LLC)

1-919-736-1110

UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPN GP):

1-984-974-5006

Patient Label Here

PSYCHIATRY GENERAL CONSENT FOR TREATMENT (PAGE 1 OF 6)
HIM# 741s

I understand that the University of North Carolina Health Care System (UNC Health Care) is an integrated health system made up of various entities, including (but not necessarily limited to) UNC Hospitals; Rex Hospital, Inc.; Caldwell Memorial Hospital, Incorporated; Chatham Hospital, Inc.; Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital; the University of North Carolina at Chapel Hill, School of Medicine; Johnston Health Services Corporation; Johnston Specialty Physician Services, Inc.; Nash Hospitals, Inc.; Nash MSO, Inc.; NHCS Physicians, Inc.; UNC Rockingham Health Care, Inc. ; Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ; Wayne MRI, LLC **;** UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC (each referred to in this form as a "UNC Health Care affiliate" or collectively as "UNC Health Care affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health Care affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health Care affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health Care affiliates but are authorized by UNC Health Care affiliates to provide treatment and care to me as a patient of the UNC Health Care affiliate. I am aware that the providers listed on Exhibit A to this consent are independent contractors of UNC Health Care affiliates, as listed, and they provide services to the UNC Health Care affiliate's patients in accordance with their professional judgment. The providers listed on Exhibit A are not employees or agents of the UNC Health Care affiliate. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at UNC Health Care affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health Care affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of the UNC Health Care affiliate or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

For more detailed information about the way my information may be used or released, I can read UNC Health Care's *Notice of Privacy Practices.*

I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care

I further give permission to UNC Health Care affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3)**,** drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a

particular UNC Health Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

I further authorize release of financial information and activity related to payment for services to:

Name of Individual: _____

Relationship to Patient: _____

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health Care affiliate on my behalf. I authorize UNC Health Care affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health Care affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health Care affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care affiliate's records, including wireless telephone numbers, for the purpose of communicating with me about my health care, servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke this consent at any time by calling or writing to UNC Health Care.

Personal Property

I understand that UNC Health Care affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health Care affiliates from all liability for the loss or theft of, or damage to, such belongings.

Insurance Billing for Psychiatric Services

We will bill your insurance company for services provided to you unless you check "no" below and agree to be personally responsible for payment of all claims related to your psychiatric care. Do you want claims and related health information submitted to your health insurance carrier?

_____ (*initial*) **NO**, I do not want claims or related health information submitted to my health insurance carrier, and I agree that I am personally responsible for payment of all claims related to psychiatric services provided.

Increased Confidentiality for Psychiatric Services

State and federal laws require increased confidentiality for mental health, developmental disability, and substance abuse services. **Unless required by law, UNC Health Care will not release any information to people inquiring about me and the mental health and substance abuse services I receive without my consent (see specific options below*).***

Patient List

As a convenience to patients and visitors, UNC Health Care keeps a list of patients currently receiving services so that we may provide the location of the patient in the facility and the patient's general condition to people who ask for patients by name.

_____ (*initial*) **YES**, I want to release my information in the UNC Health Care patient list.

Religious Information

UNC Health Care may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation.

_____ *(initial)* **YES**, I want to be included in UNC Health Care list provided for clergy.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family and friends under the following conditions: (1) the information is related that individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition or death.

_____ *(initial)* **YES**, I want personal health information shared with family and friends.

Disclosure of Records for Civil Commitment Proceedings

If I am receiving mental health and/or substance abuse treatment under a civil commitment proceeding, UNC Health Care System may be asked to disclose my results of examinations by physicians and records - including but not limited to mental health and substance abuse treatment records - to my appointed legal counsel Dolly Whiteside, the Supervising Attorney for Office of Special Counsel of the North Carolina Indigent Defense Services, or to her designee. This disclosure would be solely for the purpose of representing me in my civil commitment proceeding.

_____ *(initial)* **YES,** I want my information released to Dolly Whiteside or to her designees if necessary to represent me. My consent to this disclosure is subject to revocation at any time except to the extent that UNC Health Care System has already acted in reliance on it, and if not expressly revoked will terminate upon the termination of the related civil commitment proceeding.

FOR RESIDENTIAL OR INPATIENTS ONLY

Who would you like to be notified in case of a medical emergency or transfer to another facility?

NAME: _____ TELEPHONE NUMBER: _____

Who would you like to be notified if a restrictive intervention, such as seclusion or restraint, is used?

NAME: _____ TELEPHONE NUMBER: _____

_____ ***(initial)*** **I DO NOT want any information released in case of emergency, transfer, or restrictive intervention.**

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____ _ DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

_____

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay**.

_____ DATE: _____ TIME: _____

GUARANTOR OF PAYMENT SIGNATURE

_____

PRINTED NAME

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals ("UNCH")
I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals' patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. ("Rex")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, psychiatrists, OB hospitalists, radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

Caldwell Memorial Hospital, Incorporated ("Caldwell")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologist, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. ("Chatham")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee")
I am aware that the radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation ("Johnston")
I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. ("Nash")
I am aware that all the physicians who practice at Nash and may treat me, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, medical and radiation oncologists, EKG readers, hospitalists (including primary care hospitalists, pediatric hospitalists, neonatologists and surgicalists), bariatric surgeons, cardiologists, psychiatrists, wound care physicians, and their respective nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ("Wayne")
I am aware that the radiologists, pathologists, anesthesiologists, emergency room physicians, surgeons, psychiatrists, internists, nephrologists, oncologists, EKG readers, cardiologists, wound care physicians, intensivists, hospitalists and any other independent physician and their nurse practitioners and physician assistants, are independent contractors who provide services to Wayne's patients in accordance with their professional judgment. These practitioners are not employees or agents of Wayne.

Wayne MRI, LLC ("Wayne MRI")
I am aware that the radiologists at Wayne MRI are independent contractors who provide services to Wayne MRI in accordance with their professional judgment. These practitioners are not employees or agents of Wayne MRI.

UNC Rockingham Health Care, Inc. ("Rockingham")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rockingham patients in accordance with their professional judgment. These practitioners are not employees or agents of Rockingham.

EXHIBIT B

NOTICE OF NONDISCRIMINATION

UNC Health Care and its affiliated Network Entities comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. UNC Health Care and its affiliated Network Entities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

A. Free Aids and Services

UNC Health Care and its affiliated Network Entities:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need to receive these services, contact the individual identified below (Section C), for the Network Entity location where you are receiving services.

B. Grievances

If you believe that UNC Health Care or an affiliated Network Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the following individuals (Section C), depending on where you are receiving services. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the individual identified below, for the Network Entity location where you are receiving services, is available to help you.

C. Contacts

Network Entity	Person to Assist with Free Aids and Services	Person to Assist with Grievances
UNC Medical Center (UNC Hospitals; UNC Faculty Physicians; UNC Health Care Shared Services Pharmacy; UNC Homecare; and UNC Home Health)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu
Caldwell Memorial Hospital, Inc.	Patient Care Coordinator 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5100	Risk & Regulatory Department 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5555 E-mail: RiskMgtUNCCaldwell@unchealth.unc.edu
Chatham Hospital, Inc. and **Chatham Imaging Services of Pittsboro, LLC**	Interpreting Services Director 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4770	Director of Quality and Risk Management 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4015
Johnston Health Services Corp. (d/b/a **Johnston Health**)	Telephone Operator 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: (919) 934-8171	Compliance Director 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: 919-938-7121
Henderson County Hospital Corp. (d/b/a **Margaret R. Pardee Memorial Hospital**)	Interpreter Services 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 696-4644	Civil Rights Coordinator 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7998
Nash Health Care Systems (Nash Hospitals, Inc.; Nash MSO, Inc.; and NHCS Physicians, Inc.)	Community Outreach/Emergency Management Coordinator Nash Health Care Systems 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-3461 Fax: (252) 962-3347	Coordinator for Quality Support Services & Risk Management Nash Health Care Systems 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-8767 Fax: (252) 962-8855
UNC REX Healthcare (Rex Hospital, Inc.; Rex Surgery Center of Wakefield, LLC; Rex Surgery Center of Cary, LLC; Rex Wakefield Wellness, LLC; and Rex Radiation Oncology, LLC)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Quality Programs 4420 Lake Boone Trail Raleigh, NC 27607 Phone: (919) 784-3429
UNC Rockingham Health Care, Inc.	Administrative Supervisor 117 East Kings Highway Eden, NC 27288 Phone: (336) 520-7592 ext. 1712229	Director of Quality and Risk Management 117 East Kings Highway Eden, NC 27288 Phone: (336) 627-4212

UNC Physicians Network, LLC; and **UNC Physicians Network Group Practices, LLC**	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Human Resources Executive 2000 Perimeter Park Drive Suite 200 Morrisville, NC 27560 Phone: (984) 215-4032 E-mail: contactuncpn@unchealth.unc.edu
Wayne Memorial Hospital, Inc. (d/b/a Wayne UNC Health Care) (Wayne MRI, LLC)	Patient Care Coordination Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 731-6407	Patient Experience Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 587-2273 Email: patient.experience@waynehealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

D. Attention

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電：
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 연락처:
- ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। इस पर कॉल करें:
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:
- સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો:
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:
- Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá:
- గమనిక: మీరు తెలుగు భాషను మాట్లాడేవారు అయితే, భాష సహాయక సేవలు మీకు ఎటువంటి ఛార్జీలు లేకుండా ఉచితంగా అందుబాటులో ఉన్నాయి. ఈ నంబర్‌కు కాల్ చేయండి:
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:
- ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم:

UNC Medical Center (UNC Hospitals, UNC Faculty Physicians, UNC Shared Services Center Pharmacy, UNC Homecare, and UNC Home Health):

1-984-974-5006

Caldwell Memorial Hospital:

1-828-757-5100

Chatham Hospital and Chatham Imaging Services of Pittsboro:

1-984-974-5006

UNC REX Healthcare (Rex Hospital; Rex Surgery Center of Wakefield; Rex Surgery Center of Cary; Rex Wakefield Wellness; and Rex Radiation Oncology):

1-984-974-5006

Johnston Health:

1-919-934-8171

Margaret R. Pardee Memorial Hospital:

1-828-696-4644

Nash Health Care Systems (Nash Hospitals, Nash MSO, and NHCS Physicians):

1-252-962-8000

UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPN GP):

1-984-974-5006

Wayne Memorial Hospital (Wayne MRI, LLC)

1-919-736-1110

UNC Rockingham Health Care

1-336-520-7592 ext. 1712229

Rex Bariatric Specialists

Appointment Date:	
Name:	DOB:
Referring Physician:	Office Phone Number:
Primary Care Physician:	Office Phone Number:
Decision Maker in the Event of an Emergency:	
Decision Maker's Phone Number:	

Allergy: Please list all allergies and reactions	**Reaction**

Pharmacy Name	**Pharmacy Address**

Current Medications:

Medication name	**Dosage**	**Amount You Take Daily**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Medical History: Please mark all that apply.

Acid Reflux/Heart Burn		Arthritis	
Anemia		Asthma	
Anxiety		Bipolar Disorder	
Blood Clots		Heart Arrhythmias (Atrial fibrillation)	
Cancer		Heart Disease (Heart attack)	
Congestive heart failure		Hepatitis (Liver infection)	
Chronic Constipation		High Cholesterol	
Chronic Diarrhea		HIV/AIDS	
Cirrhosis/Liver disease		Hypertension	
COPD/Lung fibrosis		Hypothyroidism or Hyperthyroid	
Depression		Kidney Disease	
Diabetes Mellitus Type 1 or 2		Lung Disease	
Diverticulitis		Pancreatitis	
Epilepsy		Pseudotumor Cerebri	
Fibromyalgia		Sleep Apnea	
Gallbladder disease		Stroke	
Gastric Ulcers		Other:	
Gout		Other:	

Surgical History: Please mark all that apply.

Appendectomy		Hysterectomy	
Back/Spine Surgery		Joint Replacement	
Brain Surgery		Open Heart Surgery	
Breast Surgery		Pacemaker	
Colon or Rectal Surgery		Plastics Surgery	
C-section		Prostate surgery	
Cosmetic Surgery		Small Intestine Surgery	
Defibrillator		Stent Placement	
Eye Surgery		Valve Replacement	
Fracture Repair		Vasectomy	
Gallbladder Surgery		Other:	
Hernia Surgery		Other:	

Prior Bariatric Surgery	Type:	
Results	Pre-op weight	Maximum weight loss
When/Where/Surgeon Name?		

Family History:

Relationship	Living/Deceased	Heart Disease	Cancer	Clotting Disorder	Diabetes	Hypertension	Kidney Disease	Lung Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

Social History: Please mark all that apply.

Current tobacco/nicotine use (also Vaping/Dipping)		Type?	How much per day?
Prior tobacco history		Type?	Quit Date?
Current alcohol use		How Often?	How Much?
Current drug use (also CBD/ marijuana)		Type of Drug?	How Often?

Domestic Abuse History:

Is abuse, violence, or sexual assault a problem for you in any way? ☐ Yes ☐ No

Does your partner/caregiver threaten you in any way? ☐ Yes ☐ No

System Review: Please list any active problems?

Constitutional		Visual disturbance		**Gastrointestinal**		**Blood**	
Appetite change		Hearing loss		Abdominal distention		Easy bleeding/bruising	
Chills		Tinnitus (ringing)		Abdominal pain		Blood clots	
Sweating		Hoarseness		Rectal bleeding		**Skin**	
Fatigue		Nose bleeds		Blood in stool		Pallor	
Fever		Voice change		Constipation		Rash	
Weight change		Dental problems		Diarrhea		Swelling	
Nervous System		**Heart and Lungs**		Nausea		**Psychiatric**	
Headaches		Chest pain		Vomiting		Nervous/anxious	
Dizziness		Leg swelling		**Muscle/Joints/Bones**		Self-injury	
Fainting		Palpitations		Arthralgia (joint pain)		**Other**	
Memory loss		Apnea		Back pain		**Urinary System**	
Eyes/Ears/Throat		Chest tightness		Gait problem		Frequent urination	
Redness		Wheezing/Stridor		Myalgia (muscle pain)		Blood in urine	

Obstructive Sleep Apnea Evaluation

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

1. Sitting and Reading	
2. Watching TV	
3. Sitting inactive in a public place (e.g. a theater or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch with alcohol	
8. In a car, while stopped for a few minutes in traffic	
Total Score:	

Sleep Apnea Treatment:

1. Are you currently using a dental device for snoring or sleep apnea?	Type of device
2. Have you ever worn a dental device or snoring or sleep apnea?	Type of device
3. Are you currently using CPAP/bi-level therapy? ☐ Yes ☐ No	
4. Have you ever been placed on CPAP/Bi-level therapy? ☐ Yes ☐ No	When did you start therapy?
5. Have you ever had surgery for snorting or sleep apnea? ☐ Yes ☐ No	

Sleep Behaviors: Please mark all that apply.

I have sometimes fallen asleep at inappropriate times such as driving, eating, or during a conversation.	
I have been told that I snore loudly.	
I sometimes wake up with a headache.	
I have been told that I stop breathing when I sleep.	

Mental Health History: Please mark all that apply.

Have you ever been diagnosed with any of the following:

Alcoholism	
Anxiety	
Bipolar Disorder	
Depression	
Obsessive Compulsive Disorder	
PTSD	
Schizophrenia	
Other:	

1. Have you ever been hospitalized for a psychiatric condition?
    a. If so when? _____
    b. Reason? _____
    c. Where? _____
2. Are you currently receiving treatment by a psychiatrist for medication management?
    a. Name of Psychiatrist _____
3. Are you currently receiving counseling from a psychologist?
    a. Name of Psychologist? _____
4. Over the last 2 weeks, how often have you been bothered by the following problems (score in the box below)?

0 = not at all
1= Several days
2= More than half the days
3= Nearly every day

a) Little interest of pleasure in doing things	
b) Feeling down, depressed, or hopeless	
c) Trouble falling or staying asleep or sleeping too much	
d) Feeling tired or having little energy	
e) Poor appetite or overeating	
f) Feeling bad about yourself, or that you are a failure, or have let yourself or family down	
g) Moving or speaking slowly where other people have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	
Total Score:	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Rex Bariatric Specialists

Name:
DOB:

NUTRITIONAL AND DIET QUESTIONNAIRE

A. Weight/Dieting History:

1. When did you begin to struggle with weight gain?
    a. Life-long struggle since childhood
    b. At age _____

2. Please list your heaviest adult weight (exclude pregnancies): _____ lbs _____ age.

3. Please list your lowest adult weight: _____ lbs _____ age.

4. Have you tried weight loss through structured dieting or other treatment? ☐ Yes ☐ No

5. If yes, list all food/ liquid diets or treatments attempted. Many insurance carriers require this information; therefore, please provide an accurate and complete listing.

Common Diets/Programs:
21 Day Diet
Atkins/Low Carb
Grapefruit
Jenny Craig
Liquid Protein
Metabolife
Nutri-System
Optifast/Medifast
Paleo
Physicians Weight Loss Center
Slim Fast
South Beach Diet
TOPS
Weight Watchers
Volumetrics
Zone Diet

Behavioral Treatments:
Diet Counseling/Worked with Dietitian
Exercise Trainer
Hypnosis
Personal Physician
Residential Diet Center

Name of Diet/Treatment	Lbs. Lost	Physician directed?

6. List all medications used by you for weight loss. Listed below are the most common medications. Please provide an accurate and complete list of any medications used in the past: Acutrim, Alli, Bontril, Didrex, Phentermine, Xenical, Dexatrim, Fen/Phen, Meridia, Redux.
7.

Medication & Dose	Start year	Length (Mos.)	Lbs. Lost	Physician directed

NUTRITIONAL PRE-SCREENING ASSESSMENT

8. What is motivating you to have weight loss surgery? Please list 3 reasons that will help motivate you to meet your goals.
    a._____

    b._____

    c._____

9. Have you had weight loss surgery in the past?

    a. Physician:_____
    b. Date:_____
    c. Type of Surgery: _____
    d. Weight When You Began Program:_____
    e. Total Pounds Lost:_____

10. Have you ever been diagnosed and/ or have been treated for an eating disorder in the past?
    *a. Explain*_____

11. Do you have diabetes?
    a. No
    b. Yes
        i. Type 1 Diabetes
        ii. Type 2 Diabetes (known as adult onset)

    Are you testing daily blood sugars daily? _____
    If yes, what is your recent blood sugar range? _____
    Do you use insulin? _____
    Type_____ Units_____
    Type_____ Units_____

12. Are you on dialysis? _____
    *Renal dietitian contact info:*_____

13. Current use of nicotine?
    (ie. Cigarettes/e-cigarettes/cigars/pipes/chewing tobacco/nicotine gums or patches)
    a. Type? _____
    b. Frequency/Amount _____

NUTRITIONAL PRE-SCREENING ASSESSMENT

Diet Behaviors (circle all that apply)

1. Current challenges to improving my health include:
   a. Lack of time
   b. Lack of motivation
   c. Work Schedule
   d. Too expensive
   e. Social Calendar
   f. Family responsibility
   g. Illness or physical limitation
   h. Traveling for work, etc
   i. Other_____

2. My hidden sources of extra calories most likely come from:
   a. Large portions
   b. Soda/other beverages
   c. Sweets
   d. Chips
   e. Fried foods
   f. Eating while cooking
   g. Going out to eat
   h. Eating with distractions (TV/driving/etc)
   i. Eating when upset/stressed
   j. Eating when bored
   k. Other:_____

3. How do you feel about making behavioral changes?
   a. Ready to start making changes now
   b. Ready to think about making changes
   c. Not ready to make any changes to my current lifestyle

4. How many meals do you eat out per week?

a.	Breakfast: _____	Fast food	Café	Cafeteria	Restaurant
b.	Lunch: _____	Fast food	Café	Cafeteria	Restaurant
c.	Dinner: _____	Fast food	Café	Cafeteria	Restaurant

5. Do you skip any meals?
   a. Breakfast How many days per week?_____
   b. Lunch How many days per week?_____
   c. Dinner How many days per week?_____

6. How often do you eat between meals?
   a. Seldom
   b. 1 time per day
   c. 2 time per day
   d. Graze throughout the day

7. What best describes your evening meal?
   a. Seldom eat dinner
   b. Lightest meal of the day
   c. Moderate size meal
   d. Largest meal of the day

8. Which sources of protein do you eat most often?
   a. Red meat (beef and pork)
   b. Fish and Chicken
   c. Eggs and Dairy
   d. Tofu, beans, and lentils

9. How your proteins are normally prepared? (choose all that apply)
   a. Grilled
   b. Sautéed with butter/ oils
   c. Baked/ Roasted
   d. Fried

NUTRITIONAL PRE-SCREENING ASSESSMENT

10. How many servings of fruit do you consume each day: _____

11. How many servings of vegetables do you consume each day: _____
    a. Prepared with cheese, butter, or dressing
    b. Canned
    c. Fresh
    d. Frozen

12. Which types of carbohydrates do you choose most often:
    a. I avoid carbs
    b. Whole grains (brown rice/bulgar/barley/quinoa/ whole grain breads)
    c. Starchy vegetables (potatoes/peas/corn/beans)
    d. White/refined carbs (white rice/white pasta/white bread)
    e. Sweets (candies/cakes/muffins/etc)

13. How often do you eat low-fat dairy products?
    a. Seldom
    b. 1-2 times per week
    c. 1 time per day
    d. 2 times per day

14. Which types of drinks do you choose most often?
    a. Water
    b. Flavored water
    c. Fruit juice
    d. Coffee
    e. Sweet Tea
    f. Unsweet Tea
    g. Regular Soda
    h. Diet Soda/ seltzer waters

15. How many ounces of water do you drink on average each day? _____ ounces

16. How much alcohol do you consume?
    a. Less than 1 beverage per month
    b. 2-4 beverages per month
    c. 1-2 beverages per week
    d. 1-2 beverage per day
    e. 2-3 beverages per day
    f. Specify other: _____

17. How often do you exercise for 20 minutes or more each week?
    a. Seldom
    b. 1-2 times per week
    c. >3 times per week

    Please specify current exercise type/ duration_____
    Do you have any limitations/current barriers to increasing exercise?_____
    What exercise has your physician asked you to do? _____

18. How many hours of sleep do you typically get a night?
    a. 1-2 hours
    b. 3-4 hours
    c. 5-6 hours
    d. 7 or more hours.

19. What changes have you made since starting the bariatric program?
    a. Reduced refined carbohydrates (“white foods”)
    b. Increased physical activity
    c. Increased water consumption
    d. _____