Karl W. Strom M.D., F.A.C.S.
Mina Ibrahim M.D.
Jonathan Reich M.D., F.A.C.S
Silvia Fresco M.D., F.A.C.S.
Richard Greco, DO
James Nangeroni, DO
Kevin Bain D.O.
Justin Stufflebeam D.O.

NJ Weight Loss Doctors

Name: Please include maiden or previous name			Primary Physician:	
Address:			Physician Phone:	
			Name of Pharmacy:	
City, Zip Code, State:			Pharmacy Phone #:	
Preferred Phone #			Alternate Phone #	
DOB:	Age:	Sex: M / F	Marital Status:	SS#
Email Address:			Emergency Contact Name / Relationship / Phone#:	
Employment Status: ☐ Full Time ☐ Part Time ☐Self Employed ☐ Retired Student ☐ Unemployed				
Occupation:	Employer:		Business Phone:	

INSURANCE INFORMATION – PLEASE PROVIDE REFERRALS IF REQUIRED

PRIMARY INSURANCE	
INSURANCE COMPANY NAME :	POLICY ID #:
NAME OF SUBSCRIBER:	SUBSCRIBER SS#:
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE	
INSURANCE COMPANY NAME :	POLICY ID #:
NAME OF SUBSCRIBER:	SUBSCRIBER SS#:
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT:

CONSULTS – FOR OFFICE USE

Cardio	
Pulmonary	
GI	
Psych	
Nutrition	
PCP / Other	

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I am entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims on my behalf to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me. In the event that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out to check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for the professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co- payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to : (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R.§2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I understand that my provider may be out of network with my health insurance plan for my scheduled elective procedure. I have been given the contact information for the billing company and am able to request an estimate of my out of pocket cost.

I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Patient Signature _____ Date _____

Montclair Surgical Associates	Monmouth Surgical Specialists	Monmouth Surgical Specialists	Stafford Surgical Specialists
123 Highland Ave Suite	727 N. Beers St., 2 East	516 Lawrie Street	1100 Rt. 72 W. Suite 303
Glen Ridge, NJ 07028	Holmdel, NJ 07733	Perth Amboy, NJ 08861	Manahawkin, NJ 08050
973-429-7600	**732-739-5925**	**732-952-0444**	**609-978-3202**

Acknowledgement of HIPAA privacy notice and designation of disclosure

Patient Name: _____ Date of Birth:_____

I wish to be contacted in the following manner (check all that apply):

Home/Cell Telephone Number: _____
___Ok to leave a message with detailed information

Written Communication:
__Ok to mail to my home address that I listed on registration.

Email Address: _____
___Ok to contact me via email

Designation of Certain Relatives, Close Friends and Other Caregivers:

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of practice making limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____Relationship:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the Physician's Practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as: *A basis for planning my care and treatment. *A means of communication among the many health professionals who contribute to my care. *A source of information for applying my diagnosis and surgical information to my bill. *A means by which a third-party payer can verify that services billed were actually provided, and I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent.

I understand that the Physician's Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Physician's Practice reserves the right to change their notice and practices prior to implementation, in accordance with Section 164-520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** (**circle one**) the terms of this consent.

I have been presented with and understand the Physician's Practice Notice of Privacy Policy.

Email Address _____ ☐ Check box if ok to use email as a method of contact

Signature of Patient/Parent/Guardian:_____Date: _____

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Monmouth Surgical Specialists and Dr. Karl Strom, Dr. Silvia Fresco, Dr. Jonathan Reich, Dr. Juan Lujan, Dr. Marius Calin, Dr. Robert Barbalindo, Dr. James Nangeroni, Dr. Kevin Bain, Dr. Richard Greco (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Monmouth Surgical Specialists and Dr. Karl Strom, Dr. Silvia Fresco, Dr. Jonathan Reich, Dr. Juan Lujan, Dr. Marius Calin, Dr. Robert Barbalindo, Dr. James Nangeroni, Dr. Kevin Bain, Dr. Richard Greco for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

WEIGHT MANAGEMENT MEDICINE
PATIENT HISTORY QUESTIONNAIRE

*The information requested below is very important. To give you the best care, we must have complete and **honest** answers. Please be thorough and print clearly with black ink. Thank you.*

Patient Name: _____ Date of Birth: _____

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Events	Age	Weight
Child obesity		
High School Graduation		
College years		
Marriage		
Lowest weight in past 5 years		
Highest weight in past 5 years		
Weight one year ago		
Other:		
Other:		
Other:		

What is your Goal Weight? _____
Do you use a home scale? ☐Yes ☐No How often do you weight yourself? _____
Have you had bariatric surgery? ☐Yes ☐No
If No, are you interested in learning more about bariatric/weight loss surgery? ☐Yes ☐No
If Yes, which procedure and when: ☐LapBand ☐Gastric ByPass ☐Gastric Sleeve Date: _____

What is motivating you to seek this type of intervention for weight control and/or loss?

_____

SOCIAL HISTORY:

1. Do you use any tobacco? ☐Yes ☐No Do you vape? ☐Yes ☐No
   a. If yes – what? _____
   b. How often/much? _____
2. Do you drink alcohol? ☐Yes ☐No
   a. If yes – what kind/how much/often? _____
3. Any drug use? ☐Yes ☐No
   a. If yes – type/how much/often? _____
4. History of drug overdose? ☐Yes ☐No
   a. If yes – when? _____

FAMILY HISTORY:

Is there Obesity in the family? ☐Yes ☐No If yes, please list: _____

_____

Are there any medical illnesses in your immediate family? ☐Yes ☐No If yes, what/who:

Diabetes? ☐Yes ☐No Who: _____

Hypertension? ☐Yes ☐No Who: _____

Coronary Artery Disease? ☐Yes ☐No Who: _____

Cancer? ☐Yes ☐No Type: _____ Who: _____

Other: _____ _____

WEIGHT LOSS ATTEMPT HISTORY:

Please list ALL weight loss attempts, physician-supervised programs as well as self-monitored diets. Please take the time to be as thorough as possible.

Age you first started dieting: _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ACUPUNCTURE						☐Yes ☐No
JENNY CRAIG						☐Yes ☐No
ATKINS						☐Yes ☐No
KETO-DIET						☐Yes ☐No
Calorie Counting						☐Yes ☐No
RICHARD SIMMONS						☐Yes ☐No
WEIGHT WATCHERS						☐Yes ☐No
SOUTH BEACH						☐Yes ☐No
ALLI						☐Yes ☐No
NUTRI-SYSTEMS						☐Yes ☐No
OPTI-FAST or MEDI FAST						☐Yes ☐No
OVER THE COUNTER List Names:						☐Yes ☐No
PHENTERMINE						☐Yes ☐No
MERIDIA						☐Yes ☐No
METABOLIFE						☐Yes ☐No
XENICAL						☐Yes ☐No
OTHER:						☐Yes ☐No
Any Rx med for weight loss? Rx Name(s):						☐Yes ☐No
Other Prescription/Shots						☐Yes ☐No
Other bariatric program? Which Surgeon?						☐Yes ☐No
Any support groups?						☐Yes ☐No

List any other physician-supervised and documented weight loss attempt:

_____

_____

FOOD INTAKE:

What specific Food Plan/Diet are you currently following, if any? _____

How many meals do you consume per day? _____

Do you skip meals? ☐Yes ☐No Number of snacks per day? _____

Do you eat breakfast? ☐Yes ☐No

How late is your dinner? _____ When is your typical bedtime? ____ Do you snack after dinner? ___

Do you snack between meals? ☐Yes ☐No

If so, what? _____

How often? _____

Is snacking from habit? ☐Yes ☐No Depression? ☐Yes ☐No

Boredom? ☐Yes ☐No Do you binge eat? ☐Yes ☐No

If so, what? _____

How often? _____

Do you have any eating related problems or concerns? ☐Yes ☐No If yes, please explain: _____

_____

Are you willing to cook or prefer purchasing meals? _____

Do you feel deprived of any foods? ☐Yes ☐No

Do you feel restricted of any foods? ☐Yes ☐No

Any foods/beverages not tolerated? ☐Yes ☐No If so: _____

_____

Do you have any diet restrictions?

Vegan? ☐Yes ☐No

Vegetarian? ☐Yes ☐No

Lactose intolerant? ☐Yes ☐No

Gluten Free? ☐Yes ☐No

Other? _____

How many grams of protein do you get in daily? (best estimate) From drinks? _____

From food? _____

How much **WATER** do you drink in a 24-hour period? ☐24oz (3 cups or less) ☐32oz (4+ cups) ☐64oz (8+ cups) Other: _____

What do you drink other than water? _____ How much? _____

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	***Place***	***Food/beverage***	***Amount***
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

PHYSICAL ACTIVITY:
Do you exercise regularly? ☐Yes ☐No If yes, do you have an exercise regimen? Please list in table below.
Do you have any physical restrictions that keep you from exercising? If Yes, Explain? _____

Type of Physical Activity (Walking, Yoga, Cardio, Weights, Swim, etc)	Intensity (Light, medium or high)	Daily?	How often?	Comments
		☐Yes ☐No		
		☐Yes ☐No		

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following? Check all that apply.

Psychologic

1. Do you have any of the following? (Please check all that apply)
   a. ☐Depression ☐Panic attacks ☐Anxiety ☐Bipolar Disease ☐Obsessive Compulsive Disorder ☐Eating Disorder ☐other: _____
   b. Seeking treatment? ☐Yes ☐No
   c. Medications? ☐Yes ☐No Please list under medications
2. Do you have a history of suicide attempt or suicidal ideation? ☐Yes ☐No
   If so, when: _____
3. Are you currently seeing a psychologist/psychiatrist/therapist? ☐Yes ☐No.

Sleep Health

1. How many hours do you typically sleep per night? _____ hours
2. If you have insomnia, do you have trouble falling asleep or staying asleep? ☐Yes ☐No
3. Have you been told you stop breathing when sleeping? ☐Yes ☐No
4. Do you have excessive daytime sleepiness? ☐Yes ☐No
5. Have you been diagnosed with Sleep Apnea? ☐Yes ☐No
6. If yes, do you use a CPAP or oral device? ☐Yes ☐No

Cardiovascular

1. High blood pressure ☐Yes ☐No
2. If yes – medication? ☐Yes ☐No Please list under medications
3. Heart Attack? ☐Yes ☐No When? _____
4. Heart Bypass surgery? ☐Yes ☐No When? _____
5. Stents? ☐Yes ☐No When? _____
6. Pacemaker? ☐Yes ☐No When? _____

Endocrine

1. Diabetes? ☐Yes ☐No
2. If Yes, do you have Low Sugar Episodes?
3. If Yes, please write your current A1C blood test value if known? _____
4. If Yes – medication? ☐Yes ☐No Please list under medications
5. Thyroid problems? ☐Yes ☐No
6. Medications? ☐Yes ☐No Please list under medications

Gastrointestinal

1. Heartburn? ☐Yes ☐No
   If yes – how often a week? _____
2. Medications? ☐Yes ☐No Please list under medications
3. Do you get pain in your upper abdomen after eating or in the middle of the night other than heartburn? ☐Yes ☐No
4. Have you ever been told you have gallstones? ☐Yes ☐No
5. Have you ever been told you have a fatty liver? ☐Yes ☐No

Respiratory

1. Do you have asthma? ☐Yes ☐No
2. Do you have COPD/Emphysema?
   If yes – medications? ☐Yes ☐No Please list under medications
3. How far can you walk before you get short of breath? _____

Musculoskeletal

1. Do you have joint pain? ☐Yes ☐No
2. If yes – where? _____
3. Do you take medication for this? ☐Yes ☐No
   Please list under medications
4. Have you see an Orthopedic MD or this? ☐Yes ☐No
5. Have you had surgery for this? ☐Yes ☐No
   a. If yes – when and what? _____
6. Are you waiting for a joint replacement until you lose weight? ☐Yes ☐No

Any other medical history/conditions besides listed above?

_____

_____

_____

Medications (Including Vitamins): ☐ I currently do not take any medication

Medication	Dosage	Frequency	Comments

Please attach medication list if applicable

Thank you for taking the time to answer all the questions.

I certify that all the information that I provided on this questionnaire is true, accurate, and complete.