McLaren

BARIATRIC AND
METABOLIC INSTITUTE

MBSAQIP

METABOLIC AND BARIATRIC SURGERY
ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

ACCREDITED CENTER

G-3200 Beecher Road, Suite MBI
Flint, Michigan 48532

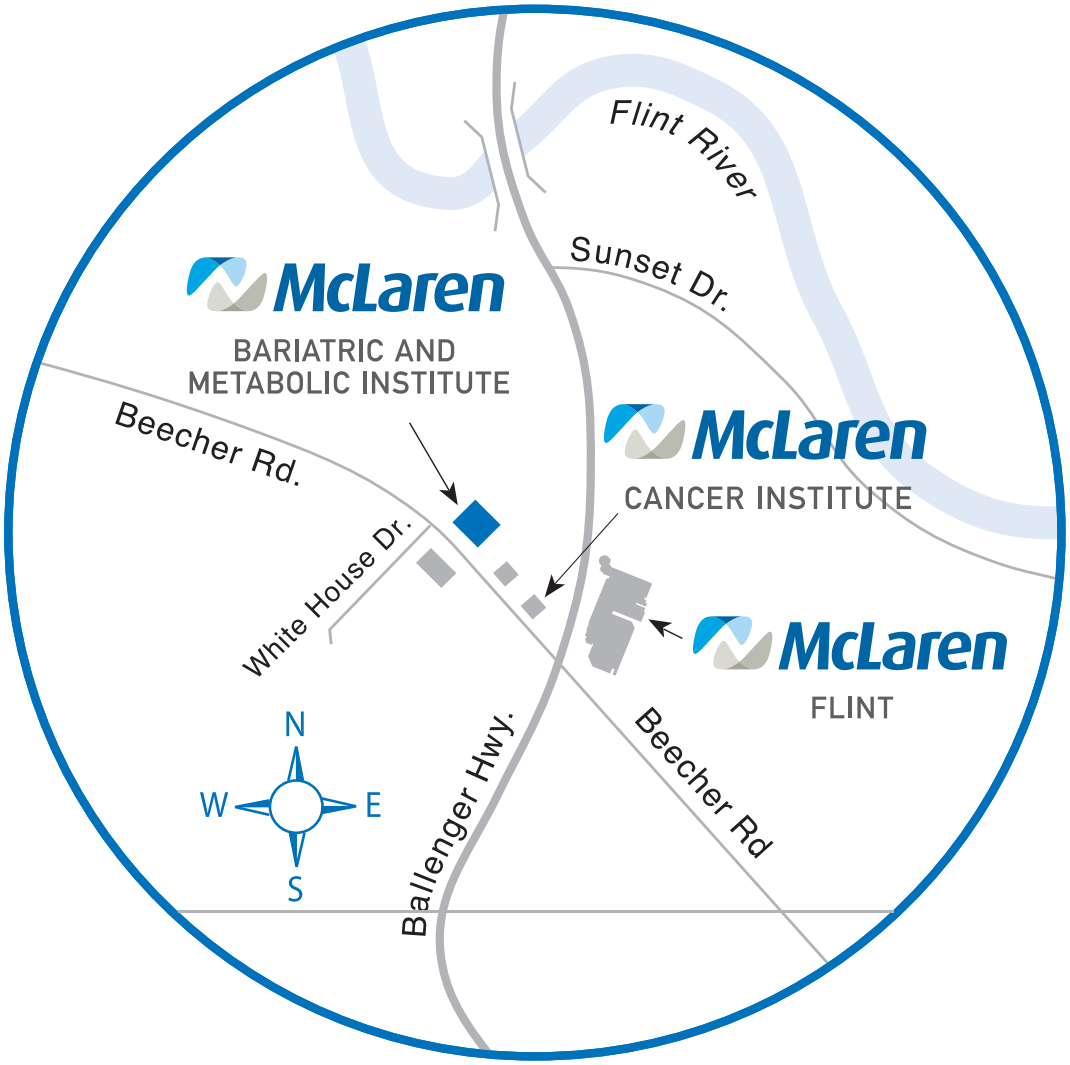
tel	(810) 342 5470
tollfree tel	1 888 342 5470
fax	(810) 342 5788

Appt. Date: _____

Appt. Time: _____

Please complete all forms and bring this packet with you to your first appointment. If it is not completed, you will not be able to see the doctor.

If a cancellation notice is not received prior to the scheduled appointment, you may be charged a $45.00 no show fee.



1/4 mile west of Ballenger Hwy.

M-31018 (4/15)

NOTICE OF PRIVACY PRACTICES

Version Effective: June 2022

McLaren

MHCC-550 8.5x11 (06.22)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WHO WILL FOLLOW THE PRACTICES OUTLINED IN THIS NOTICE?

McLaren Health Care ("McLaren") provides health care to our patients in partnership with physicians, health care providers, and other professionals and organizations in an organized health care arrangement (hereinafter referred to as we, our or us). This is a joint Notice of our information privacy practices. The practices in this Notice will be followed by:

- Any health care professional who participates in an organized health care arrangement with us to assist in providing treatment to you. These professionals may include, but are not limited to, physicians, allied health professionals, and other licensed health care professionals;
- All subsidiaries and departments of our organization, except our health plans, including hospital, emergency department, outpatient services, mobile units, skilled nursing, clinics/ hospital-owned physician practices, urgent care centers, home health, hospice, cancer centers, and retail outlets as well as those outside our system with whom we've contracted for assistance in providing services.
- Our employees, staff and volunteers, including corporate offices and affiliates.

A complete list of McLaren organizations covered by this Notice may be found on our Website; if you do not have a computer you may request a list by calling our Compliance Line.

OUR PLEDGE TO YOU

We understand that health information about you is private and personal, and we are committed to protecting it. Each time you visit a hospital, physician or other health care provider, a record of your visit is made. This Notice applies to the records of your care at McLaren, whether created by facility staff or your personal physician. Other health care providers providing treatment to you may have different practices or Notices regarding their use and disclosure of health information about you maintained in their own offices or clinics.

We are required by law to make sure that health information that identifies you is kept private, give you this Notice of our legal duties and privacy practices concerning your health information, and follow the terms of the Notice that is currently in effect.

CHANGES TO THIS NOTICE

We may change our practices from time to time. Changes will apply to health information we already hold, as well as new information after the change occurs. If we make a significant change in our practices, we will change our Notice and post the new Notice in prominent locations in our facilities and on our Website at: www.mclaren.org/privacy.

OUR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Your health information, linked with your name or other identifying information is used in many ways such as providing care, obtaining payment for your care and running our business. Disclosures of your health information for purposes described in this Notice may be made in writing, orally, electronically, or by facsimile. As permitted by HIPAA, Ohio and Michigan State laws, we may use or disclose your health information for several purposes. Here are some examples of how we may use or disclose your health information.

Treatment: We may use your health information to provide you with medical care in our facilities or in your home. We also may share your health information with others who provide care to you, such as hospitals, nursing homes, doctors, nurses, physician assistants, medical and nursing students, therapists, technicians, emergency service and transportation providers, medical equipment providers, pharmacies, and others involved in your care. For example, different hospital departments may share your health information to coordinate your prescriptions, laboratory, x-rays and other medical needs.

Payment: We may use and disclose your health information as needed to get paid for the medical care that we provide to you or to assist others who care for you to get paid for that care. For example, we may share your health information with a billing company or with your health insurance plan to obtain prior approval for your care or to make sure your plan will cover your care.

Health Care Operations: We may use or disclose your health information for our quality assurance activities and as needed to run our health care facilities. We may use your health information in combination with other patients' health information to compare our efforts and to learn where we can improve our care and services. We also may use or disclose your health information to get legal, auditing, accounting and other services and for teaching, business management and planning purposes. We may disclose your information to businesses and individuals (e.g., medical transcription service) who perform services for us involving health information as long as they agree to protect the privacy of that information.

Health Information Exchange (HIE): We participate in Health Information Exchanges such as Great Lakes Health Connect and CommonWell. As permitted by law, your health information is electronically shared with HIEs for the purpose of improving the overall quality of health care services provided to you (e.g., by avoiding unnecessary duplicate testing). Health Information Exchanges are required to maintain appropriate administrative, technical and physical safeguards to protect the privacy and security of your protected health information. Only authorized individuals may access the HIE and use your protected health information. You have the right to request in writing that we not disclose any of your protected health information to the HIE. Except for health information required by law to be shared with the HIE, you may 'opt-out' or restrict the sharing of your health information by contacting the Information Privacy Office listed at the end of this notice. Opting out may result in a health care provider not having access to information necessary for the provider to render appropriate care to you.

Media Condition Reports: We may release your health information for an update to the media if the media requests

information about you using your full name. The following information may be disclosed: your condition described in general terms such as “good”, “fair”, “serious”, or “critical”. You have the right to request that this information not be released.

Appointments Reminders: We may use your health information to contact you about upcoming appointments. These reminders may be communicated by using the following methods: text message, email, mail and telephone.

On-Site Contacts: While in our facilities, we may need to contact you by overhead page or ask you to write your name on a sign-in sheet. In these instances, we take reasonable precautions to protect your privacy.

Individuals Involved in Your Care or Payment for Care: We may share health information about you with a friend or family member who is involved in your medical care, with others whom you designate as involved in your medical care or with disaster relief authorities so that your family can be notified of your location and condition.

Patient Directory: We may include certain limited information about you in the patient directory while you are a patient at any of our hospitals. This information may include your name, location in the hospital, your general condition as well as your religious affiliation and may also be released to people who ask for you by name. You have the right to opt out of being listed in our patient and/or religious directory.

Treatment Alternatives, Health Benefits, and Services: We may use and disclose your health information to tell you about treatment alternatives, and health-related benefits and services. We may use your information to tell you about our products or services or to provide gifts of nominal value to you or your family.

Fundraising Activities: We may use certain information, including, but not limited to, name, address, and phone number, to contact you to raise money for a McLaren hospital. The money raised will be used to expand and improve the services and programs we provide to the community. You have the right to opt out of fundraising communications.

Research: Under certain circumstances, we may use or disclose health information about you, for research purposes, without your authorization. However, the information would be limited to health information needed in preparation for conducting research (e.g., to help look through records with specific medical conditions to aide in finding a cure). Research projects must be cleared through a special approval process before any health information is disclosed to the researchers and the researchers will be required to protect the health information they receive.

Releases Required by Law: We may use health information about you without your prior permission for several other reasons. Subject to applicable law, we may give out health information about you to other persons or entities to carry out their duties for (a) public health purposes (such as, births, deaths, public health surveillance); (b) abuse, neglect or domestic violence reporting; (c) health oversight audits or inspections; (d) coroners or medical examiner services; (e) funeral arrangements; (f) organ donation; (g) tracking of FDA-regulated products; (h) worker’s compensation purposes; (i) emergencies, such as disaster relief efforts; (j) data de-identification; and (k) data aggregation. We also share health information with others when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative order. We may share immunization records with schools if required by state law, and if you or a parent, guardian or other individual acting in the place of a parent agrees.

Releases Requiring Your Permission: We will not use or disclose your health information without your written authorization, except as listed above. Except in limited circumstances, use or disclosure of psychotherapy notes, or use and disclosure of health information for marketing purposes, or the sale of health information require specific written permission. If you give us written permission, you can cancel that permission, except for uses and disclosures already made based on your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Access and Copies: In most cases, you have the right to look at or get a copy of health information that we use to make decisions about your care. If you request copies of the information, however, we may charge a fee for cost of copying, mailing or other related supplies. If we deny your request to look at the information or get a copy of it, you may give us a written request for a review of that decision. In some instances your health information may not be available due to our retention policy.

Correct or Update: If you believe that information in our records about you is incorrect or if important information is missing, you have the right to request that we change the records, by submitting a request in writing and including your reason for requesting the change. We may deny your request to change a record if the information was not created by us; if it is not part of the health information kept by us; or if we determine the record is complete and correct. If we deny your request to change, you may submit a written request to review that denial.

List of Disclosures: You have the right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations, or information provided directly to you or your family, or information that was disclosed with your authorization.

Confidentiality: You have the right to request that health information about you be shared with you in a confidential manner, such as sending mail to an address other than your home.

Notification of a Breach: If our actions result in a breach of your unsecured health information we will notify you of that breach.

Restrict Disclosures to Your Health Plan: You may request that we not share health information with your health plan about care or services you received, if you pay in full out of pocket for those services and make the request in writing at the time the services are provided.

Copies of Our Notice of Privacy Practices: You may ask for a copy of our current Notice at any time. If the Notice was sent to you electronically, you may request a paper copy.

Complaints: If you have any questions about this Notice of Privacy Practices, or questions or complaints about the handling of your health information, you may contact the Information Privacy Office, in writing or call or submit a report to our Compliance Line. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

Who to Contact: To exercise any of the rights described above, please send a written request to our Information Privacy Office at the address listed below, or download and complete the Privacy Request form located on www.mclaren.org/privacy. If you do not have access to a computer, then you may call our Compliance Line and request a form be mailed to you. Completed forms may be mailed to our address below, emailed to privacy@mclaren.org or faxed to 810-342-1450.

McLaren Health Care
Information Privacy Office
One McLaren Parkway, Grand Blanc, Michigan 48439
Compliance Line: 1-866-642-2667

McLAREN FLINT
McLAREN BARIATRIC AND METABOLIC INSTITUTE
PERSONAL INFORMATION QUESTIONNAIRE

(adapted from the WALI, Wadden and Foster, 2001 & Healing the Hungry Self, D. Price 1996)

IDENTIFYING INFORMATION

Name: _____ Birth Sex: ❑ M ❑ F Age: _____ Birthdate: _____ / _____ / _____

How would you describe your gender? _____ What are your Pronouns? _____

Address: _____ Home Phone: (_____) _____

_____ Work Phone: (_____) _____

Mobile Phone: (_____) _____

Ethnicity: ❑ Native American ❑ Asian ❑ African-American/Black ❑ Hispanic ❑ White
❑ Other: _____

WEIGHT HISTORY

Your present weight: _____ Your present height: _____

Your ideal weight: _____ When is the last time you weighed your ideal weight? _____

What is specifically motivating you to lose weight now? _____

_____

What makes this a good time in your life to lose weight? _____

_____

_____

Please check the sentence below that best describes you:

- ❑ I definitely will not be able to devote 30 minutes daily to weight control
- ❑ I'm not sure if I can find 30 minutes daily for weight control.
- ❑ I can definitely find 30 minutes daily for weight control.
- ❑ I can devote more than 30 minutes daily to weight control.

Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10 which 1 = "not at all confident" and 10 = "extremely confident." Your number is _____

At what age were you first overweight by 10 pounds or more? _____ yrs old

What has been your highest weight after age 21? _____ lbs at _____ yrs old

What has been your lowest weight (not due to illness) that you have weighed after age 21? _____ lbs at _____ yrs old, maintained for _____ yrs.

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PT.

MR.#/RM.

DR.

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PERSONAL INFORMATION QUESTIONNAIRE

Was this weight reached through a weight loss effort? ❑ Yes ❑ No

If yes, how did you reach this weight?

_____

_____

Do you ever, or have you ever tried to lose weight by:

Making yourself vomit	❑ Yes	❑ No
Using water pills (diuretics)	❑ Yes	❑ No
Using laxatives	❑ Yes	❑ No
Going on very restrictive diets	❑ Yes	❑ No
Strenuous exercising	❑ Yes	❑ No
Fasting	❑ Yes	❑ No

Check the statement that best describes you: "During the past 6 months my weight has.."

- ❑ Decreased more than 10 pounds
- ❑ Decreased 5 – 10 pounds
- ❑ Been relatively stable
- ❑ Increased by 5-10 pounds
- ❑ Increased by 10 pounds or more

What was your weight:

6 months ago: _____ lbs
1 year ago: _____ lbs
2 years ago: _____ lbs

What has triggered weight gain after previous losses?

_____

_____

_____

Describe your present weight:

❑ Very Overweight ❑ Slightly Overweight ❑ Average Weight

How do you feel about the way you look at your present weight:

❑ Satisfied ❑ Neutral ❑ Dissatisfied ❑ Very Dissatisfied

How does your present weight effect your daily activities:

❑ No effect ❑ Some Effect ❑ Often Interferes ❑ Extreme Effect

Describe:

_____

_____

_____

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DR.

EATING BEHAVIORS

Do you ever feel that your eating pattern is abnormal or unusual compared to other people, either in amount eaten or rate of eating?

❑ Yes ❑ No ❑ Unsure

Do you ever eat large amounts of food quickly in a short amount of time? ❑ Yes ❑ No

Do you ever eat large quantities of food deliberately out of the sight of other people? ❑ Yes ❑ No

Do you ever plan bouts of overeating? ❑ Yes ❑ No

Do you ever have episodes of overeating that you would refer to as binges? ❑ Yes ❑ No
If yes what kind of food would you eat in an episode of overeating:

_____

How much of this food would you eat in an episode of overeating:

_____

How frequently do episodes like this tend to occur:

_____

Which types of food are particularly troublesome/tempting (e.g., sweets, starches, etc):

_____

Do you ever eat large amounts of food and stop only because of:

Abdominal or stomach pain ❑ Yes ❑ No
Someone is present or watching ❑ Yes ❑ No
Because you fall asleep ❑ Yes ❑ No

Do you ever feel out of control while you are eating or have the fear that you will not be able to stop eating?

❑ Yes ❑ No

Do you ever feel ashamed, guilty, blue, or disgusted with yourself after eating a large amount of food?

❑ Yes ❑ No

PT.

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DR.

Weight Loss Attempts: Make a list of the diets, medications, and/or other measures you have tried to reduce your weight, how old you were when you tried them, when you tried each one, how much weight you lost, the length of time the weight stayed off, and how much weight you gained back.

Weight Loss Effort	Age	Start and Stop Date	Pounds Lost	Time Kept Off	Weight Regained

LIFESTYLE BEHAVIORS

How physically active are you?

❑ Active ❑ Average ❑ Inactive

What do you do for physical activity, how often, and for how long at a time?

Activity	Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PERSONAL INFORMATION QUESTIONNAIRE

Please indicate the degree to which you believe each of the following behaviors causes you to gain weight. In answering these questions, please use the 5-point scale below. Pick the one number that best describes how much the behavior contributes to your increased weight:

1 = Does not contribute at all
2 = Contributes a small amount
3 = Contributes a moderate amount
4 = Contributes a large amount
5 = Contributes the greatest amount

____ Eating too much food
____ Overeating at breakfast
____ Overeating at lunch
____ Overeating at dinner
____ Snacking between meals
____ Snacking after dinner
____ Eating because I feel physically hungry
____ Eating because I crave certain foods
____ Continuing to eat because I don't feel full after a meal
____ Eating because I can't stop once I've begun
____ Eating because of the good taste of food
____ Eating in response to the sight/smell of food
____ Eating while cooking food
____ Eating when anxious
____ Eating when tired
____ Eating when bored
____ Eating when stressed
____ Eating when angry
____ Eating when depressed
____ Eating when celebrating
____ Eating when happy
____ Eating with family/friends
____ Eating at business functions

Who prepares meals in your home? _____

Who does the grocery shopping in your home? _____

MEDICAL HISTORY

Who is your current primary care provider (doctor)? _____

Address: _____

Telephone: _____

When did you last have a complete physical examination? _____ / _____ / _____

Please indicate if you have had or have any of the medical conditions listed below:

Heart disease ❑ Yes ❑ No
Angina (chest pains) ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Back Problems ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Gout ❑ Yes ❑ No
Gallbladder disease ❑ Yes ❑ No
Thyroid problems ❑ Yes ❑ No
Diabetes (Type I or II) ❑ Yes ❑ No
Sleep Apnea ❑ Yes ❑ No
Other: _____ ❑ Yes ❑ No

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List all medications (including any over the counter, herbal, natural) that you take regularly and for what:

MEDICATION	PRESCRIBED/TAKEN FOR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any medication, drugs, or foods that you are allergic to:

_____

List any hospitalizations or operations. Indicate your age at each hospital admission:

_____

_____

Do you see any of your medical problems as being complicated by your weight? Which ones? _____

_____

_____

SUBSTANCE USE

Do you smoke or vape currently? ❑ Yes ❑ No

If you smoke, how many cigarettes do you smoke a day: _____

How many years have you smoked: _____

Have you smoked or vaped in the past? ❑ Yes ❑ No

When did you quit: _____ / _____ / _____

How many cigarettes did you smoke? _____

Did you gain weight after quitting? _____

Do you use any recreational drugs currently: ❑ Yes ❑ No

Have you used any recreational drugs in the past: ❑ Yes ❑ No

Have you ever tried to quit using recreational drugs: ❑ Yes ❑ No

When: _____ / _____ / _____

During the past year:

How many glasses of wine did you drink a week _____

How many bottles of beer did you drink a week _____

How many mixed drinks or liqueurs did you have a week _____

Have you ever tried to quit drinking: ❑ Yes ❑ No

When: _____ / _____ / _____ How long: _____

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Have you ever been through substance abuse treatment for drugs or alcohol? ❑ Yes ❑ No

When: _____

MENTAL HEALTH HISTORY

List any counseling services that you have received which may include individual, group, or marital therapy

Reason for Contact	Counselor/Therapist	# of Sessions	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently, or have you ever been under the care of a psychiatrist, or treated for depression or anxiety by your family doctor? ❑ Yes ❑ No

If yes, who, when, diagnosis, and medications:

_____

Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No

PSYCHOSOCIAL INFORMATION

Who lives at home with you: _____

Present Marital Status: ❑ Single ❑ Cohabitate ❑ Engaged ❑ Widowed
❑ Married ❑ Separated ❑ Divorced

Please answer the following questions about each significant relationship:

Dates of relationship	Dates of termination	Reason (divorce, death)	Number of Children
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are currently in a significant relationship, please answer the following questions:

Partner's Age: _____ Weight: _____ Height: _____

Partner's Occupation: _____ Place of Employment: _____

How long employed: _____

Describe your partner's weight: ❑ Overweight ❑ Average ❑ Underweight

Is he/she/they partner supportive of you pursuing a weight management program at this time? ❑ Yes ❑ No

How does he/she demonstrate support for you? _____

_____

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PERSONAL INFORMATION QUESTIONNAIRE

List your children/step children's ages, sex, height, weight and check off whether they are overweight, average, underweight. Include any children from previous relationships, whether they are living with you or not:

Age	Sex	Weight	Height	Overweight	Average	Underweight
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑

Is your father living? ❑ Yes Age _____

❑ No Age at, and cause of, death: _____

Medical History: _____

Occupation: _____

Is your mother living? ❑ Yes Age _____

❑ No Age at, and cause of, death: _____

Medical History: _____

Occupation: _____

Describe your parent's weights while you were growing up (check one for each):

	Overweight	Average	Underweight
Father	❑	❑	❑
Mother	❑	❑	❑

Describe your parent's current weight or weight throughout your adulthood:

	Overweight	Average	Underweight
Father	❑	❑	❑
Mother	❑	❑	❑

List your brother's and sister's age, birth sex, present weight, height, and check off whether they are overweight, average, or underweight:

Age	Sex	Weight	Height	Overweight	Average	Underweight
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑

What is your current occupation? _____

What is your current place of employment? _____

How long have you worked here? _____

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Are you not working due to any disability: ❑ Yes ❑ No

What is the disability: _____

Circle the last year of school attended:

Grade School	High School	College			
1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4	Associate's	Bachelor's	Masters PhD

Did you ever repeat any grades in elementary or high school? ❑ Yes ❑ No

If yes, which grade(s) _____

Ever receive special education services: ❑ Yes ❑ No Describe: _____

_____

_____

Please indicate if you are currently experiencing any stress in your life related to the following events. Complete each item by checking the appropriate box:

Work:	❑ Yes	❑ No
Health:	❑ Yes	❑ No
Relationship with spouse/significant other:	❑ Yes	❑ No
Activities related to your children:	❑ Yes	❑ No
Activities related to your parents:	❑ Yes	❑ No
Legal/financial trouble:	❑ Yes	❑ No
School:	❑ Yes	❑ No
Moving:	❑ Yes	❑ No
Other: _____	❑ Yes	❑ No

Are you planning any major life changes (e.g. new job, moving, relationship, etc.) during the next 6 months?

❑ Yes ❑ No

If yes, please briefly describe below:

_____

_____

_____

_____