Bariatric Institute

Registration Forms

Before you get started

Gather the following information to complete your forms:

- Insurance card
- Medical records
- Medication names and doses
- Doctor information

Your accurate and complete medical history must be received before your visit to Bariatric Institute to avoid appointment cancellations or delays.

Please complete all the forms in this packet.

Questions? Call 888-927-3220.

Personal information

Date: _____

Prefix: _____ First name: _____ MI: _____ Last name: _____ Suffix: _____
Date of birth: _____ Age: _____ Social Security #: _____
Driver's license #: _____ Email: _____
Current mailing address: _____
City: _____ State: _____ ZIP code: _____
Home phone #: _____ Cellphone #: _____
Secondary address _____
City: _____ State: _____ ZIP code: _____

Sex: ◯ Male ◯ Female ◯ Undifferentiated ◯ Unknown

Marital status: ◯ Single ◯ Married ◯ Partnered ◯ Divorced ◯ Widowed

If you are married or otherwise partnered, what is the person's name? _____

Race:
◯ Black/African-American ◯ American Indian ◯ Asian
◯ White ◯ Hispanic or Latino ◯ Alaska Native
◯ Native Hawaiian/Pacific Islander ◯ Decline to answer ◯ Other _____

Ethnicity: ◯ Not Hispanic or Latino ◯ Hispanic or Latino ◯ None

Preferred language: ◯ English ◯ Spanish ◯ Decline to answer ◯ Other _____

Emergency contact information

I authorize Bariatric Institute to VERBALLY discuss my selected information with the following people, including translation from/to another language:

Contact name 1: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Contact name 2: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

By selecting from the following options and signing, I authorize Bariatric Institute to **discuss** the following information with my emergency contact(s):

- ☐ My appointment information
- ☐ My billing and payment information
- ☐ My lab/test results
- ☐ My location within the facility
- ☐ My medical information (including symptoms, diagnosis, medication and treatment)

Cancellation of this authorization must be submitted in writing.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Insurance information

We MUST obtain this information to coordinate with your insurance company and provide the best care.

Primary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Secondary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Tertiary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Attorney information

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information about your attorney:

Name: _____ Phone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Auto insurance

If your condition or injury is the result of an automobile accident, please provide the following information about the automobile insurance involved:

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of policyholder: _____ Relationship: _____
State accident occurred in: _____ Adjuster name: _____

Have auto benefits been exhausted? ◯ Yes ◯ No

If yes, enter date benefits exhausted: _____

Workers' compensation

If applicable, please take a moment to provide the following information:

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of insurance adjuster: _____

Patient history - Chief Complaint/Physician Information

Chief complaint

What is your primary concern?

How long have you had pain? _____

Does your pain interfere with your activities of daily living (self-care, meal prep, home maintenance)? ◯ Yes ◯ No

If yes, please explain:

Are you able to stand for long periods of time? ◯ Yes ◯ No

Are you able to sit for long periods of time? ◯ Yes ◯ No

Does your pain interfere with your daily job functions? ◯ Yes ◯ No

If yes, please explain:

Have you been diagnosed previously with a **condition** such as hiatal hernia, gallstones, acid reflux?

◯ Yes ◯ No

If yes, please explain:

Physician information

Primary care physician name: _____ Phone #: _____ Fax #: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Specialist name 1: _____ Type: _____ Phone #: _____ Fax #: _____

Specialist name 2: _____ Type: _____ Phone #: _____ Fax #: _____

Specialist name 3: _____ Type: _____ Phone #: _____ Fax #: _____

Specialist name 4: _____ Type: _____ Phone #: _____ Fax #: _____

Specialist name 5: _____ Type: _____ Phone #: _____ Fax #: _____

By providing this information, you authorize Bariatric Institute to send a summary of your care and/or medical records to the providers listed above.

Patient history - Medical/Surgical

Medical history

Please indicate if you have any of the following and explain below:

- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Cholesterol disease
- ☐ Congestive heart failure
- ☐ Coronary heart disease
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gastrointestinal disease
- ☐ GERD
- ☐ Headaches/migraines
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart rhythm abnormalities
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney/bladder disease
- ☐ Liver disease
- ☐ MRSA
- ☐ Multiple sclerosis
- ☐ Nervous system disease
- ☐ Osteoporosis
- ☐ Pacemaker/defibrillator
- ☐ Prior infections
- ☐ Pulmonary (lung) disease
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Skin disorders
- ☐ Sleep apnea
- ☐ Strokes/TIA
- ☐ Tremors
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vascular disease
- ☐ Other

If any of the above was checked, please explain:

Surgical history

Please indicate if you have had any of the following procedures, conditions or surgery on any of these areas:

- ☐ Abdominal
- ☐ Anesthesia complications
- ☐ Angioplasty/stents
- ☐ Ankle/knee/hip
- ☐ Appendix
- ☐ Arm
- ☐ Breast
- ☐ Chest/lung
- ☐ Coronary artery bypass
- ☐ Foot
- ☐ Gallbladder
- ☐ Hand
- ☐ Hernia
- ☐ History of dura leak
- ☐ Leg
- ☐ Low back/lumbar spine
- ☐ Mid back/thoracic spine
- ☐ Neck/cervical spine
- ☐ Nerve stimulator or pump
- ☐ Pacemaker/defibrillator
- ☐ Prostate
- ☐ Spine (neck/back)
- ☐ Thyroid
- ☐ Tonsil/wisdom teeth/adenoids
- ☐ Uterus/ovary
- ☐ Varicose veins
- ☐ Wrist/shoulder/elbow

If any surgery in the past year, please explain:

Surgical procedure #1

Surgeon name:_____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY): _____ Level: _____ Outcome: _____

Surgical procedure #2

Surgeon name:_____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY): _____ Level: _____ Outcome: _____

Patient history - Medications/Allergies

Current Medications: Please clearly list below any prescription medications, over-the-counters and pain medications.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	12-1-2024	Cholesterol

Supplements: Please clearly list below any herbs, vitamins or supplements.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Supplement name 20mg	Twice a day	12-1-2024	Immune support

Allergies: Please clearly list any allergies, medical or nonmedical.

Type of allergy	Reaction	Severity (please check one)			
		Mild	Moderate	Severe	Life threatening
Example: Penicillin	Hives, itching and rash		X		

Pain management care

Are you currently taking prescription pain medications? ◯ Yes ◯ No

Who prescribes your pain medication? ◯ Primary care physician ◯ Pain management physician ◯ Other

Physician name: _____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Fax#: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Patient history - Family/Social

Family history

Place a check by any family conditions and fill in the rest of the row.

Mother = **M**, Father = **F,** Sibling = **S**, Child = **C,** Maternal Grandparent = **MG,** Paternal Grandparent = **PG**

Condition (Please check)		Which family member?						Onset	Current family member condition
		M	F	S	C	MG	PG		
	Arthritis								
	Bleeding disorders								
	Cancer								
	Heart disease								
	Diabetes								
	Kidney/bladder disease								
	Liver disease								
	Neuromuscular disease								
	Osteoporosis								
	Pulmonary disease								
	Stroke								
	Thyroid disease								
	Malignant hyperthermia								

Social history

Have you ever used any form of nicotine or tobacco? ◯ Yes ◯ No

If so, have you received counseling to stop tobacco use? ◯ Yes ◯ No

Type of tobacco	Daily amount	Years used	Age started	Date ended
Cigarettes				
Cigar				
Pipe				
E-cigarette				
Chewing/smokeless/snuff				
Nicotine patch				

Do you drink coffee, tea or soda?

◯ Yes ◯ No

If you answered yes:

How many cups per day? _____ Per week?_____

Do you drink alcohol?

◯ Yes ◯ No

If you answered yes:

How many drinks per day? _____ Per week?_____

Please sign and date upon completion of registration forms below:

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Medication hold list

(Please keep a copy for your reference.)

Please review and sign to acknowledge that you understand the following Medication Hold List. If you are taking an over-the-counter medication not listed here and you are unsure of its actions, please consult your pharmacist or physician, or call Bariatric Institute at 1-888-927-3220, from Monday through Friday, 9 a.m. to 5 p.m. Pacific Standard Time.

The following medications **MUST BE STOPPED FIVE DAYS** prior to your surgery.

- Advil
- Aggrenox
- Aleve
- Alka-Seltzer
- Amigesic
- Anacin products
- Anaflex
- Anaprox
- Ansaid
- Apo-ASEN
- Arco Pain Tablet
- Argeric
- Arthropan
- Arthrotec
- Ascriptin
- Aspergum
- Aspirin (all products containing aspirin)
- Aspir-Low
- Aspirtab
- Bayer
- Bayer time release
- Buffex
- Bufferin
- Bufferin Arthritis
- Buffinol
- Butalbital Compound
- Butazolidin
- Cama Arthritis
- Carisoprodol Compound
- Cataflam
- Clinoril
- Combunox
- Cope
- Daypro
- Diclofenac
- Diflunisal
- Disalcid
- Doan's
- Dolobid
- Easprin
- Ecotrin 81
- Empirin
- Endodan
- Entrophen
- Equagesic
- Es Anacin
- Etodolac
- Excedrin Migraine
- Feldene
- Fenoprofen
- Fiorinal
- Flector Patch
- Floctafenine
- Flurbiprofen
- Glucosamine
- Goody's
- Halfprin
- Helidac
- Ibuprofen
- Indocin
- Indomethacin
- Instantine
- Kaopectate
- Kava
- Ketoprofen
- Ketorolac
- Lodine
- Lovaza
- Magan
- Magnaprin
- Marthritic
- Meclofenamate
- Meclomen
- Medipren
- Mefenamic acid
- Midol
- Mobic
- Mobiflex
- Momentum
- Mono-Gesic
- Motrin
- Nabumetone
- Nalfon
- Naprelan
- Naprosyn
- Naproxen
- Norgesic Forte
- Nuprin
- Ocuvite
- Oruvail
- Orudis
- Oxaprozin
- Pamperin-IB
- Pepto-Bismol
- Percodan
- Phenylbutazone
- Piroxicam
- PMS-ASA
- Ponstel
- Prevacid NapraPAC
- Relafen
- Robaxisal
- Roxiprin
- Salflex
- Salsalate
- Sine-Aid IB
- Sodium salicylate
- Soma Compound
- St. Joseph Aspirin
- Sulindac
- Suprofen
- Suprol
- Surgam
- Synalgos-DC
- Tandearil
- Talwin Compound
- Tenoxicam
- Tiaprofenic acid
- Tolectin
- Tolmetin
- Toradol
- Tricosal
- Trilisate
- Vanquish
- Vicoprofen
- Voltaren
- Zorprin

We recommend you stop taking the following supplements at least five days prior to your scheduled surgery:
St. John's wort, garlic, ginger, ginkgo biloba, ephedra (ma huang) and vitamin E.

By signing, I agree that I must not take any of these over-the-counter medications for the time frame specified. I understand that failure to follow these instructions might result in the postponement of my surgery.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Medication alert list

(Please keep a copy for your reference.)

Continue these prescribed blood-thinning medications **unless and until** Bariatric Institute has been provided with **written approval/ permission** from your doctor that you can stop the medication. If you are on any of these prescribed medications, speak to your surgeons.

If you are diabetic: Consult with the doctor who treats your diabetes about your insulin dosage or other diabetic medication. You may experience an elevation in your blood sugar before, during and/or after surgery due to the stress of surgery and the steroid medications used during the surgery. Please have a plan to address this with your local doctor who treats your diabetes so you are ready to handle elevations in your blood sugar while you are at Bariatric Institute. This could include additional checking of your blood sugar and additional insulin as needed. Our providers will check and treat your blood sugar before, during and after surgery. For your safety, we ask that you follow your regular doctor's instructions after you are released from Bariatric Institute. Please closely monitor your dietary intake to prevent blood sugar fluctuations.

Bariatric Institute will inform you of the exact date of your surgery. Medication instructions will be given after we are able to obtain written permission from your prescribing physician.

Please take time to review and sign to acknowledge that you understand the following Medication Alert List.

WARNING:

THESE MEDICATIONS CAN ONLY BE STOPPED WITH APPROVAL OF YOUR PRESCRIBING PHYSICIAN.

- Aggrenox (aspirin/dipyridamole)
- Arixtra (fondaparinux)
- Aspirin (when prescribed by your physician)
- Brilinta (ticagrelor)
- Coumadin (warfarin)
- Eliquis (apixaban)
- Fragmin (dalteparin)
- Innohep (tinzaparin)
- Lovenox (enoxaparin)
- Plavix (clopidogrel)
- Pletal (cilostazol)
- Pradaxa (dabigatran etexilate)
- Xarelto (rivaroxaban)

By signing, I understand that approval must be obtained from my prescribing physician before stopping any of these medications prior to my surgery date. **I understand that failure to follow the exact instructions regarding what day to take the last dose of these medications might result in postponement of my surgery.**

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Care Partner, nursing services and distance agreement

Patient ID (office use only) _____

Care Partner services

I understand and agree that Bariatric Institute ("BI") requires that for any surgical procedure(s) I undergo at BI's facility, I have a Care Partner. A Care Partner shall be defined as an adult 18 years or older and of able mind and body who aids and accompanies an BI patient through the entire surgical process at BI.

My Care Partner must be fully capable of:

- Providing me physical support as I walk and get in and out of bed, a car and/or a chair
- Providing me with medications and meals
- Driving and transporting me to and from any and all of my surgery-related appointments

My Care Partner must be deemed suitable by BI; he or she must agree to assume all necessary duties and responsibilities for my care until after my postoperative appointment.

I understand and acknowledge that my selected Care Partner understands instructions communicated in English. I understand and agree I am responsible to advise BI of my Care Partner's language barriers in advance of my scheduled date of any surgery and agree to reasonable alternatives communicated by BI.

I understand and acknowledge that I will have a Care Partner accompany me on the day of my surgery and that my Care Partner will remain with me for a minimum of 24 to 48 hours after discharge from my surgical procedure(s).

If requested, BI will provide me with a list of several companies in the area that can offer care services. In the event that my Care Partner fails to arrive after my surgical procedure(s) has been completed, or if I do not schedule a Care Partner, I understand and acknowledge that BI will contact a care partner service for me.

I understand and acknowledge that any fee for these licensed care partner services is separate and apart from my surgical payment(s) to BI, and that I am expressly responsible for payment of these services.

Licensed nursing services

I understand and agree that my surgeon **may** order licensed nursing services for a minimum of 24 hours following discharge from certain surgical procedure(s) I undergo at BI's facility. I understand and agree that any fee for these licensed nursing services is separate and apart from my surgical payment(s) to BI, and that I may be responsible for payment of these services.

Distance agreement

For my safety, I must stay within 15 miles of BI's facility for a minimum of 24 to 48 hours after any surgical procedure(s) I've undergone at its facility. If I request, BI will provide me with a list of local hotel partners that can accommodate me after my surgery. Any payment for these accommodations is separate and apart from my surgical payment(s) to BI. I will be responsible for payment of these accommodations and also for making hotel reservations prior to surgery day.

I have been given an opportunity to ask an BI employee any questions I might have regarding this Care Partner, Nursing Services and Distance Agreement, and all of my questions have been answered fully and satisfactorily. I confirm that I have read, understand and agree to the above.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____

Patient Financial Agreement

Thank you for choosing Bariatric Institute, APC ("Bariatric Institute"). It is important that you fully understand your financial responsibilities prior to receiving services. All patients (or their guardians, if a minor) are fully responsible for payment of all services rendered. Therefore, you must take the time to fully review the information below regarding patient financial responsibility.

This Patient Financial Policy applies to all services received from any of the following

- Bariatric Institute, APC

Insurance Coverage

- As a courtesy, Bariatric Institute will verify your insurance benefits and submit claims to your primary and secondary insurance provider, as applicable, on your behalf. However, please note that you are responsible for the full payment of any and all services provided to you, regardless of your insurance coverage.

- It is your responsibility to fully understand your insurance coverage and benefits. This includes, but is not limited to:

  - Eligibility
  - Copayment
  - Coinsurance
  - Deductible
  - Covered and Non-Covered Services
  - Referral and Authorization Requirements
  - Policy previsions
  - Exclusions
  - Limitations

Please refer to your insurance carrier's Summary Plan Description for detailed information about your insurance benefits and coverage. If you have any questions regarding your insurance benefits and coverage, we recommend contacting your insurance provider directly for clarification.

- Bariatric Institute will attempt to verify that your health insurance coverage and benefits are active at the time of your visit(s). However, if your insurance coverage is found to be inactive or invalid, for any reason or no reason at all, you will be fully financially responsible for any and all services provided.

- Bariatric Institute will attempt to determine your applicable copayment, coinsurance, or deductible prior to your appointment, based on the information provided by your insurance carrier.

- You are fully responsible for paying any and all applicable copayments, coinsurance, and deductibles at the time services are provided. Once your insurance carrier(s) have processed your claim(s), you will be billed for any remaining balance determined to be your financial responsibility. Payment is due within thirty (30) calendar days of receiving the bill. If it is determined that you have overpaid, the excess amount will be refunded to you.

- If your insurance carrier(s) deny your claim(s), in whole or in part, you are financially responsible for any unpaid amounts.

- You are responsible for promptly responding to any and all requests from your insurance carrier(s) for additional information. Failure to do so may result in claim denial, in which case you will be financially responsible for the full cost of services provided.

- You are responsible for immediately notifying Bariatric Institute of any changes to your insurance coverage, including but not limited to changes in eligibility or coverage. If the information you provide is incorrect or outdated, you will be financially responsible for any and all services rendered and charges incurred.

- Bariatric Institute is contracted with a growing network of insurance carriers and is required by federal and state law—as well as by our agreements with these carriers—to collect any and all applicable copayments, coinsurance, and deductibles in full. As such, we are legally and contractually prohibited from waiving or discounting any portion of your financial responsibility. Doing so would violate both federal and state law, as well as our contracts with your insurance provider.

- If your insurance carrier(s) issues payment directly to you for services provided by Bariatric Institute, you are responsible for promptly forwarding the full amount to Bariatric Institute. Payment should be made immediately upon receipt of funds from your insurance carrier.

Self-Pay

Patients who do not have health insurance, or who do not provide valid insurance information at the time of their appointment, will be classified as self-pay and are responsible for the full cost of services rendered.

- If you do not have active health insurance at the time of your appointment, full payment is required at the time of service.

- If you are unable to provide valid health insurance information at the time of your appointment, you will be required to pay in full at the time of service. Once valid insurance information is provided and your benefits, eligibility, and authorization are confirmed, your account may be adjusted accordingly for future appointments.

- Once we have your valid health insurance information, we will bill your insurance carrier(s) on your behalf. After payment is received from your insurance carrier(s), our billing department will issue a refund for any overpayment, minus any applicable copayments, coinsurance, and deductibles.

Medicare, Medicare Advantage, and Medicare Supplement

Your Bariatric Institute physician may or may not participate in Medicare, Medicare Advantage, or Medicare Supplement plans. If your physician participates in one or more of these programs, Bariatric Institute will bill your insurance as follows:

- If you have Medicare, Bariatric Institute will bill Medicare on your behalf. However, you are fully responsible for any and all amounts not covered or paid by Medicare.

- If you have a Medicare Advantage Plan (PPO or HMO) and your physician is contracted with your health insurance carrier, Bariatric Institute will bill your insurance on your behalf. However, you remain fully responsible for any and all applicable copayments, coinsurance, deductibles, and any and all other amounts not covered or paid by your insurance. If your physician is not contracted with your Medicare Advantage Plan (PPO or HMO), you will be fully responsible for any and all charges incurred.

- If you have Medicare along with a Supplement Plan, Bariatric Institute will bill both Medicare and your Supplement Plan. However, you are fully responsible for any amounts not covered or paid by either Medicare or your Supplement Plan.

Workers' Compensation and Third Party Liability

If your appointment is related to a work-related injury, third-party liability, or an accident, please notify Bariatric Institute immediately. This ensures proper documentation and claims processing with the appropriate party.

Other Potential Fees

You may be responsible for other fees, including, but not limited to:

- Medical Records Copy Fees

- X-Ray and Imaging Copy Fees

- Form Completion Fees (e.g., FMLA, DMV)

- Returned Check Fee

- No-Show Appointment Fee

- Costs associated with the collection of patient balances, including, but not limited to, attorneys' fees and collection agency fees, if applicable.

Medi-Cal

If you have health insurance coverage through Medi-Cal, it is your responsibility to notify Bariatric Institute prior to your visit. Your physician may or may not be a participating Medi-Cal provider. If your physician is not contracted with Medi-Cal and you do not inform us in advance, your visit may not be covered, and you may be financially responsible for all charges.

Please initial next to the statement that applies to you:

_____ I do not have health insurance coverage through Medi-Cal.

_____ I have health insurance coverage through Medi-Cal.

Please read each statement carefully, initial next to each one, and sign below.

_____ I fully understand and agree that I am fully responsible for paying any and all copayments, coinsurance, and deductibles, as applicable, in full at the time services are received. If I am a self-pay patient, I fully understand that full payment is required at the time of service.

_____ I fully understand and agree that I am solely responsible for notifying Bariatric Institute of any and all changes to my health insurance coverage, and I am fully financially responsible for payment of any and all services received.

I have read and fully understand my financial responsibilities as described herein.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____

Authorization for and Release of Medical Information

1.) AUTHORIZATION: I, _____, hereby authorize Bariatric Institute, APC and parent company, affiliates, subsidiaries, management company, successors, licensees and assignees and each of their respective owners, officers, directors, shareholders, profits interest holders, members, managers, consultants, contractors, agents, and assigns ("Bariatric Institute") to disclose to the public at large, including but not limited to medical professionals and potential and current patients (collectively, the "Covered Persons") all of the information and medical records, including, but not limited to photographs, videos or recordings, regarding the treatment and related products and services that I receive from Bariatric Institute that Bariatric Institute has in its possession ("Medical Information").

2.) PURPOSE OF THE DISCLOSURE AND USE BY THE COVERED PERSONS: For use and disclosure to inform the medical profession and the general public at large about general and bariatric surgery, procedures, techniques, and results.

3.) REVOCATION RIGHTS: I fully understand that I have the right to revoke this Authorization for Release of Medical Information at any time, for any reason or no reason at all, by sending written notice of revocation to Bariatric Institute. I fully understand that the revocation will become immediately effective upon receipt by Bariatric Institute. Any Medical Information disclosed by Bariatric Institute pursuant to this Authorization for Release of Medical Information before the effective date of the revocation, including, but not limited to any photos, videos, or recordings posted to social media platforms or websites is not subject to the revocation and do not need to be removed or otherwise made unavailable to the general public at large.

4.) FURTHER DISCLOSURE: I fully understand that because the Covered Persons are not health care providers or health plans covered by state or federal privacy regulations, my Medical Information may be re-disclosed and would no longer be protected by these regulations.

5. EXPIRATION: Unless and until this Authorization for Release of Medical Information is terminated in accordance with the revocation rights herein, I fully understand and agree that this Authorization for Release of Medical Information will continue in full force and effect until it expires on December 31, 2050.

6.) OTHER TERMS: I fully understand and agree that the signing of this Authorization for Release of Medical Information is voluntary and that neither treatment, payment, nor eligibility for health care benefits will be conditioned on my signing this Authorization for Release of Medical Information. I fully understand that I am entitled to receive an original copy of this Authorization for Release of Medical Information.

AGREED AND ACCEPTED

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____

Authorization for Release of Photographs, Audio and/or Video Recordings of Patient Images

I, _____, hereby acknowledge that Bariatric Institute, APC ("Bariatric Institute") has taken or will take photographs of me (the "Photographs") in connection with general, foregut and bariatric surgery and related products and services I receive from Bariatric Institute and may make audio and/or video recordings of me in preparation for, during and after any such contemplated or performed general, foregut and bariatric surgery and related services ("collectively, the "Recordings" and together with the Photographs, the "Covered Materials"). I hereby acknowledge and agree that I am executing this Authorization for and Release of Photographs, Audio and/or Video Recordings of Patient Images voluntarily for the purpose of informing and educating the medical profession and the general public at large which purposes constitute good and valuable consideration for such release. I acknowledge and agree that I will not have any right now or in the future to receive any monetary compensation or consideration from Bariatric Institute or any other person or entity in connection herewith. Such use shall include, but not be limited to, distributing the Covered Materials via print, visual and electronic, specifically including, but not limited to, Bariatric Institute website and social media channels.

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby irrevocably grant to Bariatric Institute and its parent company, affiliates, subsidiaries, management company, successors, licensees and assignees the unrestricted royalty-free right and permission, but not the obligation, to: (i) use, re-use, publish, re-publish, reproduce, distribute, sell, license, display, exhibit, assign and exploit the Covered Materials throughout the world in perpetuity in any manner, in whole or in part, severally or in conjunction with other photographs and/or images, in any media now or hereinafter known or hereafter devised, including, but not limited to, editorial, trade, industrial, promotional or advertising without restriction or reservation; (ii) edit, change, modify and create derivative works of the Covered Materials, without restriction or reservation, even if such edits, changes, modifications and derivative works alter or modify my image, likeness and appearance in the Covered Materials; (iii) use my name, image, likeness and appearance in and in connection with the exploitation of the Covered Materials and the rights accorded herein; and (iv) copyright the Covered Materials in Bariatric Institute's name or in the name of any of Bariatric Institute's parent company, management company, affiliates, subsidiaries, successors, assignees and licensees.

I hereby acknowledge and agree that the Covered Materials (including all reproduction thereof) and any and all rights, title, and interest therein, including, but not limited to, any and all rights under copyrights, shall be the sole and exclusive property of Bariatric Institute and its parent company, affiliates, subsidiaries, management company, successors, licensees and assignees, with the exclusive right to exploit and or dispose of the same in any manner whatsoever.

I hereby irrevocably waive any right to inspect and/or approve the Covered Materials and/or the finished product, media and/or printed matters that may use, incorporate or exhibit the Covered Materials, and in no event may I revoke or terminate any rights granted hereunder.

I hereby waive any and all rights to and forever release, discharge, and agree to forever hold harmless Bariatric Institute and its parent company, affiliates, subsidiaries, management company, successors, licensees and assignees and each of their respective owners, officers, directors, shareholders, profits interest holders, members, managers, consultants, contractors, agents, and assigns from and against any and all liability in connection with, arising out of or relating to the exploitation of the rights accorded hereunder to use my name, image and likeness in and in connection with the exploitation of the Covered Materials, or bring at any time in the future, any claims or demands or any other cause of action, including, but not limited to, assertions of: (i) rights of publicity (including, but not limited to, any allegedly improper or unauthorized use of my name, image and likeness); (ii) rights of privacy; (iii) presenting me in a false light (including, but not limited to, any allegedly false and misleading portrayal of me); (iv) copyright, trademark or other intellectual property infringement; (v) defamation (including libel and slander); (vi) breach of alleged moral rights; or (vii) any other claimed violation of a personal or property right.

This release contains the entire understanding and agreement by and between the parties regarding the subject matter hereof and supersedes any and all prior understandings and communications respecting the treatment and related products and services I receive from Bariatric Institute and the Covered Materials. No waiver, modification, or addition to this release shall be valid unless and until in writing and signed by Bariatric Institute and me. In the event that there is a dispute arising from or out of this release, I acknowledge and agree that my sole remedy shall be to seek monetary damages, and, accordingly, I irrevocably waive any and all rights to seek injunctive or equitable relief and/or to interfere in any way with Bariatric Institute's use of the Covered Materials, and/or the rights accorded pursuant to this release. This release shall be construed in accordance with the substantive laws of the State of California, without regard to its conflict of laws rules, and any dispute arising from or relating to this release shall be subject to the exclusive venue in a court of competent jurisdiction in Los Angeles, California.

I represent and warrant that I am at least eighteen (18) years of age and that I have the legal right and authority to enter into this release and grant all rights granted hereunder.

AGREED AND ACCEPTED

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____

Patient-Provider Arbitration Agreement

ARTICLE 1

It is understood and agreed that any dispute related directly or indirectly to Bariatric Institute, APC and/or its parent company, affiliates, subsidiaries, management company, successors, licensees and assignees and each of their respective owners, officers, directors, shareholders, profits interest holders, members, managers, consultants, contractors, agents, and assigns (together "Provider"), including, but not limited to, any and all claims of medical malpractice, that is as to whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration, and not by a lawsuit or resort to court process except as applicable state law provides for judicial review of arbitration proceedings. Both parties to this contractual agreement (this "Agreement"), by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

I understand and agree that this Agreement binds me and anyone else who may have a claim arising out of or related directly or indirectly to the relationship with Provider (including all treatment or services provided by Provider), including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against Provider and any consenting substitute healthcare provider, as well as Provider's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement. This procedure shall be consistent with what is required under the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3

I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4

On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto). The arbitration will be governed in all respects by the Federal Arbitration Act (the "FAA"). To the extent the FAA conflicts with California law, the FAA shall supersede California law and control. Further, this Agreement supersedes any previous agreement between the parties on the same subject matter as covered herein.

ARTICLE 5

YOU AND PROVIDER HEREBY AGREE THAT ANY CLAIM RELATED DIRECTLY OR INDIRECTLY TO THE RELATIONSHIP BETWEEN YOU AND PROVIDER, INCLUDING, BUT NOT LIMITED TO THE SERVICES RENDERED BY PROVIDER TO YOU, MUST BE BROUGHT AS AN INDIVIDUAL ARBITRATION, AND THAT NO CLAIM MAY BE BROUGHT BY EITHER PARTY AS A CLASS, COLLECTIVELY, OR REPRESENTATIVE ACTION. The parties expressly waive any right to submit, initiate, or participate in a representative capacity, or as a plaintiff, claimant or member in a class action, collective action or other representative or joint action, regardless of whether the action is filed in arbitration or in court with respect to claims related directly or indirectly to the relationship between you and Provider, including the services rendered by Provider to you. Any and all disputes regarding the interpretation of this Article shall be resolved by the arbitrator, and not the courts.

If either party initiates or joins in a lawsuit or arbitration against the other party in violation of the waivers detailed in this Article and the waiver is deemed to be unenforceable for any reason, then to the extent the waiver is invalidated, claims subject to the invalidated waiver shall no longer be subject to arbitration, but shall instead proceed in court, with all remaining claims remaining subject to arbitration.

ARTICLE 6

If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provision.

By providing you with this form, Provider has agreed to the terms of this Agreement and is requesting that you indicate your acceptance below by signing.

NOTICE: BY SIGNING THIS AGREEMENT, YOU WAIVE THE RIGHT TO A TRIAL BEFORE A JUDGE OR JURY IN FEDERAL OR STATE COURT WITH RESPECT TO ALL CLAIMS RELATED DIRECTLY OR INDIRECTLY TO YOUR RELATIONSHIP WITH PROVIDER AND INSTEAD AGREE THAT SUCH CLAIMS SHALL BE RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION. SEE ARTICLE 1 OF THIS AGREEMENT.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____

Consent

NOTICE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you fully understand and agree to the planned surgery or treatment. I authorized Bariatric Institute, APC ("Bariatric Institute") providers and such physicians, associations, assistants, and other personnel or the hospital or medical facility chosen by him or her to perform the practice of medicine with the intention to improve my general well-being, as discussed with me. At the time of treatment, I understand that I can authorize any other procedures that, in their judgment, may be advisable to my well-being, including, but not limited to, such procedures as are considered medically advisable to remedy conditions discovered during the recommended procedure.

GENERAL RISKS AND COMPLICATIONS: I am fully satisfied with my understanding of the more common risks and complications of the treatment or procedure, which are described to me in discussion with my provider. These risks include, but are not limited to, the risk of bleeding, infection, pain, injury to neurovascular structures which control sensation, motor function and viability to the procedural region, as well as anesthesia risks and death.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of the specific risks of this procedure or treatment as described to me in discussion with my provider.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatment and their possible benefits and risks as described to me in discussion with my provider.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcome or risks if no treatment is rendered. I also fully understand no treatment is always an option if I do not want to take the above discussed procedural/treatment risks.

SECOND OPINION: I fully understand that I can be offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I fully understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed, and I further authorize the disposal of any severed tissue, hardware, or member in accordance with customary hospital or medical facility practice.

OTHER QUESTIONS: I am fully satisfied with my understanding of the nature of the procedure or treatment and all of my additional questions about the treatment or procedure have been fully answered.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Printed guardian name: _____ Relationship to patient: _____