SLEEP DISORDERS CENTER
MEDICAL & SURGICAL WEIGHT MANAGEMENT
PULMONARY REHABILITATION

1345 King Street
Bellingham, WA 98229-6223
T: (360) 676-1696
F: (360) 676-6636
www.northstarmedicalspecialists.com

Informed Consent for Services

I, ____ authorize Dr. Anthony Burden at NorthStar Medical Specialists and whomever they designate as their assistants, to help me in my weight reduction efforts.

I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I have the option of choosing to use prescription appetite suppression. Risks of prescription of appetite suppression may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

Insurance Consent: I request that payment of authorized benefits be made to NorthStar Medical Specialists and the facility's participating physicians for any services furnished to me. I authorize this facility to release to Medicare and/or accident or health insurer, medical or financial information as needed for claims processing, fraud investigation or quality of care review and studies. I understand that I may revoke this consent for release of information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company regarding pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay NorthStar Medical Specialists for all charges not covered by any third party payor.

Grievance procedure: I acknowledge that the Operations Director and Medical Director make themselves readily available to discuss my concerns or questions I may have. I acknowledge that if I have a grievance of any kind, I have the right to utilize the Section 504 Grievance Procedure, posted in the facility lobby.

I have read and fully understand NorthStar Medical Specialists' Informed Consent for Services

________________________________ ___________________ ____________

Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

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Patient Registration

Patient's full name:__________________________ Social Security Number:________________

Mailing Address:____Apt#:____ Birthdate:___/___/___

City/State/Zip:____

Home Phone#:______________ Work Phone#:_______________ Sex:______ Age:_______

Employment Status: (circle one) Full time / Part time / Not employed / Self employed / Retired / Student

Marital Status: Single / Married / Divorced / Separated / Widowed Spouse's Name:______________

In case of emergency, contact:____________________________Phone#:__________________

Relationship to patient: ______________________ Spouse's Employer: ______________________

Referring physician:_________________________Primary care physician:____________________

Reason for referral: ____

How did you hear about NorthStar Medical? (circle one below)

Doctor referral / Friend/family referral / Newspaper / Radio / Other ______________________

Name of Primary Insurance Company:____

Subscriber's name:________________________________ Date of Birth:__________________

Subscriber's relationship to patient:_________________________

Subscriber's #:___________________________________ Group #:_______________________

Name of Secondary Insurance Company:____

Subscriber's name:_____________________________________Date of Birth:________________

Subscriber's relationship to patient:_________________________

Subscriber's #:___________________________________ Group #:______________________

Past Medical History

Section 1

1. Are you in good health at the present time, to the best of your knowledge? Yes No

2 Are you under a doctor's care at the present time? Yes No
If yes, for what? ____

3. Are you taking any medications at the present time? Yes No
Names/Dosages: ____
Names/Dosages: ____

4. Any allergies to medications? Yes No
If yes, what? ____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
When were you diagnosed with Diabetes? __________

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
Medications for Headaches: ______________________________

10. Do you have migraines? Yes No

11. History of Constipation (difficulty in bowel movements)? Yes No

12. History of Irritable Bowel Syndrome? Yes No

13. History of Glaucoma? Yes No

14. History of Arthritis? Yes No

15. History of Fibromyalgia? Yes No

16. History of GERD (Acid Reflux / Heartburn)? Yes No

17. History of Depression? Yes No

18. History of Urinary Incontinence? Yes No

19. Gynecologic History:
Pregnancies: Number: _________ Dates: ______________________
Natural Delivery or C-Section (specify): _________________
Menstural: Onset: _________________
Duration: _______________
Are they regular? Yes No
Pain associated? Yes No
Last menstrual period: ______________________
PMS Symptoms: Mood | Physical | Cravings (Circle and describe)
____

Hormone Replacement Therapy: Yes No

What: ___________________________________ Dosages: _______________
Birth Control Pills:
What: ___________________________________ Dosages: _______________
Last Check Up: ___________________________________

20. Serious Injuries: Yes No
Specify: ____

21. Any Surgery: Yes No
Specify: ____Date: ____________
Specify: ____Date: ____________

Section 2

1. Present Weight: _______ Height (no shoes): _______ Desired Weight: __________

2. In what timeframe would you like to be at your desired weight? _________________

3. Birth Weight: _____ Weight at 20 years of age: ______ Weight one year ago: ______

4. What is the main reason for your decision to lose weight?
____
____

5. When did you begin gaining excess weight? (Give reasons, if known):
____
____

6. What has been your maximum lifetime weight (non-pregnant) and when?
____
____

7. Previous diets you have followed and the dates and results of your weight loss.

Diets	Dates	Results
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________

8. Is your spouse overweight? Yes No

If yes, by how much are they overweight? ____________________________________

9. How often do you eat out? ____

10. What restaurants do you frequent? ____

11. How often do you eat "fast foods"? ____

12. Who plans meals? ____________ Who cooks? _________ Who shops? ___________

13. Do you use a shopping list? Yes No

14. What time of day and on what day do you shop for groceries? ___________________

15. Food allergies: ____

16. Food dislikes: ____

17. Food you crave: ____

18. Do you crave food at any specific time of the day or month? ___________________

19. Do you drink coffee or tea? Yes No

    If yes, how much daily?___________

20. Do you drink cola drinks? Yes No Diet or Regular?

    If yes, how much daily?___________

21. Do you drink alcohol? Yes No

    Type of Drink? _____________________

    How many drinks day/week __________

22. Do you use food substitutes?
    Sugar? __________ If yes, what type? _____________
    Butter? __________
    Margarine? _______

23. Do you awaken hungry in the night? Yes No

    What do you do when this happens? ______________________________________

24. Snack Habits:
    What? ______________ How much? _______________ When? __________

    What? ______________ How much? _______________ When? __________

25. What are your worst food habits? ____

26. When you are under a stressful situation that is work- or family-related, do you tend to eat more?
    If yes, please explain:____

    ____

27. Do you think you are currently undergoing a stressful situation or an emotional upset?

    If yes, please explain:____
    ____

28.

Typical Breakfast	Typical Lunch	Typical Dinner
____________________	___________________	____________________
____________________	___________________	____________________
____________________	___________________	____________________
____________________	___________________	____________________
Time eaten: __________	Time eaten: _________	Time eaten: __________
Where: _____________	Where: _____________	Where: _____________
With whom: __________	With whom: _________	With whom: __________

29. Describe your usual energy level: ____

30. Smoking Habits *(Answer only one.)*

_____ I have never smoked cigarettes, cigars or a pipe.
_____ I quit smoking _____ years ago and have not smoked since.
_____ I quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
_____ I smoke 20 cigarettes per day (1 pack).
_____ I smoke 30 cigarettes per day (1½ packs).
_____ I smoke 40 cigarettes per day (2 packs).
_____ I smoke more than 41 cigarettes per day.

31. Activity Level *(Answer only one.)*
_____ Inactive – no regular physical activity and a sit-down job.
_____ Light activity – no organized physical activity during leisure time.
_____Moderate activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy activity – constantly lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____ Vigorous activity – participation in extensive physical exercise for at least 60 minutes per session at least 4 times per week.

32. Please describe your general health goals and the improvements you wish to make:

____

____

Family History

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following?

Glaucoma	Yes	No	Who: ______________________
Asthma	Yes	No	Who: ______________________
Epilepsy	Yes	No	Who: ______________________
High Blood Pressure	Yes	No	Who: ______________________
Kidney Disease	Yes	No	Who: ______________________
Diabetes	Yes	No	Who: ______________________
Tuberculosis	Yes	No	Who: ______________________
Psychiatric Disorder	Yes	No	Who: ______________________
Heart Disease/Stroke	Yes	No	Who: ______________________

Special Needs:

Please notify our office immediately if you have specific assistance requirements. This includes, but is not limited; sight, hearing, mental health and physical disabilities.

Northstar Medical Specialists has specific policies in place to accommodate your needs while protecting the health and well being of other patients. If you require a service animal, please notify our office immediately.

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Notice of Privacy Practices

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

The privacy of your medical information is important to us. At NorthStar Medical Specialists, we respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others for non-permitted uses and disclosure unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to get authorization to disclose this information for payment purposes.

Use and disclosure of protected health information for treatment, payment, and health operations, to remind you, notification of family, for public health and safety, and other uses as noted below.

For Treatment**:** Information obtained by a therapist, physician, technologist, or other member of our health care team will be recorded in your medical record and used to help decided what care may be right for you.

We may also provide information to others providing your care to help them stay informed about your care.

For Payment**:** We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations**:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about your appointments and give you information about treatment alternatives or other health related benefits and services
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
  - Medical review by your health plan;
  - Accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

To remind you:
We may remind you by phone, voicemail, or mail, that you have a health care appointment with us, or request that you call us regarding your health care. You have the right to request we contact you at an alternative addressor phone number. If you request this, we will contact you at the alternative location, as requested.

Notification of family and others:
We may disclose your private health information to a “personal representative” (a person who is legally authorized to make health care decision on your behalf, such as a parent of a minor child).
In addition, we may disclose health care information about you to assist in disaster relief efforts.
You have a right to object to this use or disclosure. If you object, we will not disclose it.

For public health and safety purposes as required by law:

- to prevent or reduce a serious, immediate threat to the health of a person or the public
- to public health and legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or death

To report suspected abuse or neglect
To the Food and Drug Administration relating to problems with products
In the course of judicial/administrative proceedings
For law enforcement purposes
To correction institutions if you are in jail
With approved medical researchers

To comply with workers compensation laws
For health and safety oversight activities, e.g., shared health information with the Department of Health
For disaster relief purposes
For work related conditions that could affect employee health
To the military authorities, U.S. and foreign
To funeral directors/coroners consistent with applicable laws
For specialized government functions such as national security purposes

Other uses and Disclosure of protected health information

Uses and disclosures not in this notice as allowed and required by law, or with your written authorization

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice;
- Abide by the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting us at NorthStar Medical Specialists to pick one up.

Your Health Information Rights

The health and billing records we create and store are the property of NorthStar Medical Specialists. The protected health information in your file, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but if we decide to, we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected Health information, you may make this request in writing.
- Have us review a denial of access to your health information - except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The privacy rule does not require accounting of disclosure to covered entities for treatment, payment, or health care operations, to the individual (or representative), to persons involved in the individual's health care, or payment for health care, pursuant to an authorization, of a limited data set, for nation security purposes, to law enforcement officials in certain circumstances, incident to otherwise permitted or required uses or disclosures;
- Ask that your health information be given to you by another means, or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance;

For help with these rights during normal business hours, please contact our Privacy Manager at NorthStar Medical Specialists.

To ask for help or complain

If you have questions, want information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Manager at NorthStar Medical Specialists.

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Manager. You may also deliver a written complaint to the Privacy Manager at NorthStar Medical Specialists. You may also file a complaint with the US Secretary of Health and Human Services.

We respect your right to file a complaint with us, or the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

While you participate in your treatment at NorthStar Medical, some of your activities and treatments will be conducted in a group setting. As a result, some of your protected health information may be discussed with you in the group setting. Please sign below if you agree.

______________________________	______________________________
Patient Signature	Date and Time

____
Printed Name

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CONSENT FOR THE RELEASE OF INFORMATION
(Specified Access)

I hereby authorize NorthStar Medical to release my medical records for treatments and services to ____________________________________. *(Name of referring provider and/or any other parties authorized to have access to your medical records.)*

This access includes: (Check all that apply)

____Reading and/or copying my written medical record

____Accessing, reading and printing my computerized medical record

____Receiving phone information regarding my medical condition and treatments

____Other: Please explain:____

____

This health care consent authorizes this access for the following time frames: (Check one)

____Between ________ and ________ (If patient is a minor this agreement ends when
Beginning date Ending Date patient becomes an adult)

____This agreement is open ended and I will notify NorthStar Medical specialists if I want it revoked.

I hereby release NorthStar Medical Specialists, its agents and employees from all legal responsibility or liability that may arise from the release of this information or records.

______________________________ Witness

______________________________ Patient Signature

______________________________ Social Security No.

______________________________ Date of Birth

______________________________ Custodial parent if patient is a minor

______________________________ Relationship

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Cancellation Policy

Thank you for choosing NorthStar Medical Specialists to help you achieve a better quality of life. In the interest of conserving your time, we will make every effort to stay on schedule. Your time is valuable and except for emergency treatment of another patient, you can expect us to be prompt.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment during business hours is appreciated.

When you schedule an appointment, that time has been set aside just for you. There will be a charge for appointments cancelled with less than sufficient notice. No-show and late cancellation fees must be paid before future appointments can be scheduled.

We will hold your appointment for 15 minutes after your scheduled start time. If you arrive late on the date of your appointment, you may be asked to reschedule; however, we will do our best to provide an excellent session with the remaining time. High standards of patient care depend upon equal treatment and consideration; therefore sessions must begin and end on time.

The cancellation/no-show fee schedule is as follows:

24-Hour Notice Required for the Following:

Physician and physician assistant appointments	$75
Clinician appointments	$45
Respiratory therapy session	$45

48-Hour Notice Required for the Following:

Overnight sleep study appointments	$250

Please note, calls to cancel appointments should not be left on the office voice mail within the minimum time frame in attempt to avoid the cancellation fee. Doing so may result in a lapse of the 24 or 48-hour notice. If you have any questions or concerns, please do not hesitate to contact our office at (360) 676-1696. Thank you!

I have read and fully understand NorthStar Medical Specialists' Cancellation Policy.

____________________________________ ____________
Signature Date

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***(A)* Notifier(s):** NorthStar Associates, PLLC
***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *Weight Management Services* below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the *Weight Management Services* below.

(D) Weight Management Services	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**
• Office Consultations with Dr. Burden • Office Consultations with Martha • Body Compositions • EKG • Meal replacements and related products	• It may not be deemed medically necessary • It may be an exclusion on your plan • It may be deemed investigational per your insurance company guidelines.	$49.00-$295.00 *(Depending on type of visit)*

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *Weight Management Services* listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**
OPTION 1. I want the *Weight Management Services* listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. **OPTION 2.** I want the *Weight Management Services* listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**. **OPTION 3.** I don't want the *Weight Management Services* listed above. I understand with this choice **I am** not **responsible for payment, and** I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566