HEALTH HISTORY SUMMARY

Patient Name: ______________________________ **Date:** __________
Last *First* *M.I.*

Primary Care Physician: ______________________________

Reason for Today's Visit: ______________________________

Medications you take (please include prescription and over the counter):

____
____
____

Do you take Aspirin daily? **Yes** ☐ **No** ☐

Allergies to Medications: ______________________________

Patient Medical History ______________________________
____
____

Please List Previous Surgeries: ______________________________
____

List Any Complications: ______________________________

Number of Children: ______________ **Number of Children Breastfed:** ______________

Do You Smoke? Yes ☐ No ☐ Occasionally ☐ **If so, how much per day?** ______________

FAMILY HISTORY

Family Member	Serious Medical Conditions	Deceased?	Cause of Death?	Age
Mother		Yes ☐ No ☐		
Father		Yes ☐ No ☐		
Children		Yes ☐ No ☐		
Sibling		Yes ☐ No ☐		
Grandparent		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		

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Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

and will become part of your medical record. The information you provide will help us plan your treatment.

Legal Name *(Last, First, M.I.)*:		☐ M ☐ F	**Birth Date:** / /
Occupation:	**Height:**	**Weight:**	**Current Age:**
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Race:	☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asian ☐ Other ________________		

PRIMARY HEALTH CARE PROVIDER (I.E: Physician, Nurse Practitioner, etc.)

Name:	**Phone: ( )**
Street Address:	
How long has he/she provided medical care for you?	

OTHER TREATING PHYSICIANS

Name	Phone Number	Specialty (i.e. cardiology, endocrinology, psychiatry, etc.)

EMERGENCY CONTACT

Name:	**Relationship:**	**Phone: ( )**
Who is the person you would like notified immediately following surgery?		**Name:**
Will he/she be waiting at the hospital during your surgery? ☐ Yes ☐ No		**Phone: ( )**

MEDICATIONS TAKEN

Please list prescribed drugs and over-the-counter drugs, such as vitamins, aspirin, allergy meds, etc.

Name of Drug:	Strength:	Frequency Taken:	Reason for Taking:	Date Started:

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MEDICATIONS TAKEN (continued)

Name of Drug:	Strength:	Frequency Taken:	Reason for Taking:	Date Started:

Allergies to Medications: ☐ No ☐ Yes, if so, please explain below:

Name of Drug	Reaction you Had

PREVIOUS SURGERIES -Please indicate with a * if done **Laparoscopically**

Surgery	Date	Purpose	Complications

Have you ever had surgery to aid in weight loss? ☐ No ☐ Yes

FAMILY HEALTH HISTORY

Family Member	Age now or at Death	Cause of Death	**CHECK ALL THAT APPLY**					
			High blood pressure	Heart Problems	Diabetes	Stroke	Cancer	Obesity
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Sibling 1 ☐ M ☐ F								
Sibling 2 ☐ M ☐ F								
Sibling 3 ☐ M ☐ F								

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Please answer all of the following questions related to your current or past medical history.

CARDIOVASCULAR SYSTEM

Hypertension (high blood pressure) requiring meds	Yes ☐ No ☐	Shortness of breath	Yes ☐ No ☐
Chest pain, angina, or tightness	Yes ☐ No ☐	Fatigue	Yes ☐ No ☐
Irregular or rapid heart rate	Yes ☐ No ☐	Leg Ulcers	Yes ☐ No ☐
Congestive heart failure	Yes ☐ No ☐	Blood clots in legs	Yes ☐ No ☐
Heart murmur	Yes ☐ No ☐	Varicose veins	Yes ☐ No ☐
Mitral valve prolapses	Yes ☐ No ☐	Ankle edema (swelling of legs and	Yes ☐ No ☐
Hight cholesterol or triglycerides requiring meds	Yes ☐ No ☐		
Do you see a cardiologist	Yes ☐ No ☐	**Name:** **Phone: ( )**	
Have you had: a stress test, cardiac catheterization, angioplasty, or heart surgery?	Yes ☐ No ☐	**If yes,** please circle all procedures that apply and indicate dates below:	

ENDOCRINE SYSTEM

Diabetes requiring meds ☐ Type 1 ☐ Type 2	Yes ☐ No ☐	Hypoglycemia (low blood sugars)	Yes ☐ No ☐
Gestational diabetes (with pregnancy)	Yes ☐ No ☐	Hypothyroidism or thyroid problems	Yes ☐ No ☐
Insulin resistance (elevated blood sugars)	Yes ☐ No ☐	Please send TSH (thyroid) level drawn within last 6 months	

MUSCULOSKELETAL SYSTEM

Arthritis	Yes ☐ No ☐	Ever had treatment by a chiropractor?	Yes ☐ No ☐
Degenerative disc disease	Yes ☐ No ☐	Lupus	Yes ☐ No ☐
Degenerative joint disease	Yes ☐ No ☐	Take anti-inflammatory medications?	Yes ☐ No ☐
Joint pain	Yes ☐ No ☐	**If yes**, please list:	
If yes, circle sites affected: neck, hands, back, hips, knees, ankles, feet		Ever had physical therapy treatment?	Yes ☐ No ☐
Had joint replacement or back surgery?	Yes ☐ No ☐	**If yes**, when?	
If yes, when?		Fibromyalgia	Yes ☐ No ☐

GASTROINTESTINAL SYSTEM

Stomach ulcer requiring medication	Yes ☐ No ☐	Gallbladder problems	Yes ☐ No ☐
If yes, when and type of treatment?		**If yes,** has your gallbladder been removed? Please also list date: ____	Yes ☐ No ☐
GERD or heartburn	Yes ☐ No ☐	Had x-rays that document gallstones	Yes ☐ No ☐
If yes, daily ________ At night __________		**If yes**, please send a copy of x-ray report	
Chrones or ulcerative colitis (IBD)	Yes ☐ No ☐	Diarrhea	Yes ☐ No ☐
Irritable bowel syndrome (IBS)	Yes ☐ No ☐	Constipation	Yes ☐ No ☐

RESPIRATORY SYSTEM

Shortness of breath with activity	Yes ☐ No ☐	Snoring	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Frequent awakening to catch breath	Yes ☐ No ☐
If yes, date of last attack		Sleep apnea (stop breathing while asleep)	Yes ☐ No ☐
Bronchitis	Yes ☐ No ☐	Do you use a C-PAP or BI-PAP machine (circle)	Yes ☐ No ☐
If yes, number of occurrences in last two years		Blood clots in lungs	Yes ☐ No ☐
Pneumonia	Yes ☐ No ☐	**If yes**, do you have vena cave filter	
Are you on blood thinners	Yes ☐ No ☐	Emphysema or COPD	Yes ☐ No ☐
If yes, please list:			
Sleep Apnea Self-Test -for above respiratory section			
Do you snore?	Yes ☐ No ☐	Fall asleep frequently while reading?	Yes ☐ No ☐
Been told that you hold your breath or stop breathing during sleep?	Yes ☐ No ☐	Ever fallen asleep while driving or stopped at a light?	Yes ☐ No ☐
Do you wake up gasping for breath?	Yes ☐ No ☐	Have jerking movements while	Yes ☐ No ☐
Do you awaken with headaches	Yes ☐ No ☐	Still feel exhausted after 8 hours of sleep?	Yes ☐ No ☐

Total number of YES answers:________

If you answered YES to more than four of the above questions, you may have sleep apnea and either you should talk to your doctor about a sleep study, or we will make arrangements for one to be done. This study is painless and can significantly help improve the safety of the operation. If you have had a sleep study performed in the past six months, please fax or mail a copy of the results to our office.

GENITOURINARY SYSTEM – FEMALES ONLY

Urinary stress incontinence (loss of urine with coughing, sneezing, and/or laughing)	Yes ☐ No ☐	Polycystic ovarian syndrome	Yes ☐ No ☐
Irregular menstrual cycle	Yes ☐ No ☐	Menopause	Yes ☐ No ☐
Heavy menstrual flow	Yes ☐ No ☐	Have you had a hysterectomy	Yes ☐ No ☐
Infertility	Yes ☐ No ☐	Do you use birth control	Yes ☐ No ☐
It is strongly recommended that female patients begin using birth control prior to surgery. Weight loss may improve fertility.			

NEUROPSYCHOLOGICAL SYSTEM

Stroke	Yes ☐ No ☐	Schizophrenia	Yes ☐ No ☐
If yes, any paralysis	Yes ☐ No ☐	History of drug abuse	Yes ☐ No ☐
If yes, where?		**If yes**, how long have you been drug free?	
Seizures requiring medication	Yes ☐ No ☐	History of alcohol abuse	Yes ☐ No ☐
Vision problems	Yes ☐ No ☐	**If yes**, how long have you been alcohol free	
Depression	Yes ☐ No ☐	Eating disorders	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	**If yes**, please circle: bulimia, anorexia, compulsive overeating	
Bipolar Disorder	Yes ☐ No ☐	**If yes**, were you treated	Yes ☐ No ☐
Do you see a psychiatrist or psychologist	Yes ☐ No ☐	**If yes,** please provide name and address below:	

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WEIGHT AND DIET HISTORY

*Many insurance companies require physician documentation of weight for five years and supervised weight loss attempts. In an effort to expedite the approval process, you may want to contact your primary care physician for that documentation to be sent to us.

LIFESTYLE

How many years have you been more than 75 pounds overweight?		Do you eat sweets?	Yes ☐ No ☐
What is your lowest weight since you were 18 years old?		**If yes**, how often?	
What is your tallest height since you were 18 years		Do you drink alcoholic beverages?	Yes ☐ No ☐
How long have you been actively attempting to lose weight?		**If yes,** how many drinks per day?	
What is the maximum amount of weight you have lost?		**If yes**, what type of beverages?	
How did you accomplish that weight loss?		Do you use caffeine? (coffee, colas, chocolate)	Yes ☐ No ☐
How long were you able to maintain that weight loss?		Do you take energy drinks or pills?	Yes ☐ No ☐
How many times per day do you eat?		Are you a snacker?	Yes ☐ No ☐
What are your favorite foods?		**If yes,** what are your favorite snacks?	
Why do you think you failed with the diet programs?			

OTHER

Do you have any hearing impairments?	Yes ☐ No ☐	Do you wear glasses?	Yes ☐ No ☐
Do you wear a hearing aid?	Yes ☐ No ☐	Do you wear contact lenses?	Yes ☐ No ☐
Do you have dentures?	Yes ☐ No ☐	Do you exercise?	Yes ☐ No ☐
Do you smoke?	Yes ☐ No ☐	**If yes,** what type?	
If yes, how many packs per day and for how long?		**If yes**, how many times per week?	
If no, did you ever smoke and when did you quit?		**If no,** what prevents you from exercising?	
Do you require any aides for mobility? Circle one: cane, walker, wheelchair	Yes ☐ No ☐	Are there any religious or ethnic customs which may affect your healthcare? If so, please list:”	Yes ☐ No ☐
PLEASE NOTE: YOU WILL BE ASKED TO QUIT SMOKING PRIOR TO SURGERY TO DECREASE YOUR SURGICAL RISKS			

Patient Signature: ______________________ Date: ______________

DIETARY HISTORY

This form will be forwarded to your insurance company as part of the pre-determination process.

Please be as specific as possible when you complete this form.

WEIGHT HISTORY

Current Weight:		Weight one year ago?
Current Height:		Weight in high school?
Heaviest Weight? _______________ When? ______________		

EATING HABITS

Binge?	Yes ☐ No ☐		Stress?	Yes ☐ No ☐
Purge?	Yes ☐ No ☐		Loneliness?	Yes ☐ No ☐
Boredom?	Yes ☐ No ☐		Sad?	Yes ☐ No ☐

PHYSICIAN SUPERVISED PROGRAMS & ATTEMPTS

Product/Method	Length of Program	Number of Pounds Lost	Dates
Medifast			
Optifast			
Redux			
Pondimin			
Fen/Phen			
Phentermine/Fastin/Adipex			
Meridia			
Eating Disorder Unit		When:	Where:
Other:			
Physicians Name/Address:			

ORGANIZED DIET PLANS

Product/Method	Length of Program	Number of Pounds Lost	Dates
American Diabetes Association			
DASH Diet			
Jenny Craig			
LA Weight Loss			
Nutrisystem			
Overeaters Anonymous			
TOPS			
Weight Watchers			
Other:			

SELF-IMPOSED PRODUCTS & DIETS

Product/Method	Length of Program	Number of Pounds Lost	Dates
Accutrim			
Air Force Diet			
Ali			
Atkins			
Ayds			
Body Solutions			
Cabbage Soup Diet			
Cambridge Diet			
Cortaslim			
Dexatrim			
Diurex			
Grapefruit Diet			
Hearbal Diet			
Low Calorie Diet			
Low Fat Diet			
Relacore			
Richard Simmons Diet			
Scarsdale			
Self-Imposed Diet			
Trim Spa			
Other:			

OTHER WEIGHT LOSS ATTEMPTS

Product/Method	Length of Program	Number of Pounds Lost	Dates
Behavior Therapy			
Psychotherapy			
Acupuncture			
Hypnosis			
Fitness Centers			
Exercise Programs			
Previous Weight Loss Surgery:			

At what age did you begin your first diet?	What was your single greatest weight loss?
Were you considered overweight as a child?	How long did you sustain that weight loss?

Patient Signature: ____________________________________ Date:______________________

DISCOVERY FORM

Please let us know how you found Dr. Minkin

Patient Name: _______________________

Please check only one answer:

- ○ **Television**
- ○ **Dr. Minkin's website**
- ○ **Friend: ______________________**
- ○ **Primary Doctor**
- ○ **Word of Mouth**
- ○ **Other**
- ○ **My New Self (mynewselfbariatrics.com)**
- ○ **My New Self Seminar**

ADMINISTRATIVE FEE

All new lap band and lap sleeve candidates will be required to pay a **$75.00** non-refundable administrative/program fee. New band management patients will be required to pay a **$300.00** band management fee. This fee is not billable to the insurance company and is fully the patient's responsibility. **This fee does not guarantee approval by the insurance company and is being implemented as a processing program fee required for joining the practice.** The fee will be required before any attempts will be made for insurance requirement verification by staff or approval of the laparoscopic gastric banding or laparoscopic sleeve gastrectomy procedure by any insurance company. By signing below, I acknowledge I have received the form and understand the fee being charged is non-refundable and mandatory for all patients.

Sincerely,

Darin M. Minkin, D.O.

Patient Signature: ______________________________ Date:_________________

RELEASE OF INFORMATION FORM

Authorization to Use or Disclose Protected Health Information

I authorize the disclosure of protected health information (PHI) from my health record to the individual or facility listed below.

Patient Name: ______________________ Medical Record Number: ________________

Date of Birth: ______________________ Social Security Number: ________________

Phone Number: ______________________

Name and Address of Recipient:

To:	**From:**
Darin M. Minkin, D.O.	Name: ______________________
2355 Dougherty Ferry Road, Suite 430	Address: ______________________
St. Louis, MO 63122	______________________
(314) 965-8410 - Office	Phone: ______________________
(314) 965-8756 - Fax	Fax: ______________________

Specific Description of the Purpose of the Disclosure: Please check in box for all that apply			
	Bariatric Treatment Referral		Continued Patient Care
	Insurance Coverage of Payment		Diagnostic Purposes
	Other (specify)		

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent the office or hospital has acted on this authorization prior to the date we received the letter to revoke authorization.

To revoke my authorization, I must submit a written request to the ______________________
Insert Practice Name

______________________ ______________________
Signature of Patient Date

______________________ ______________________
Signature of Legal Representative or Guardian Relationship to Patient or Description of Authority for Patient

Notice to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains.

Verification of Patient ID:

______________ Signature of person disclosing information to recipient

______________ Date when information was disclosed

______________ Form of ID reviewed by person disclosing information to recipient. (Photo ID and/or signature when authorization was mailed.)

Date:

PATIENT INFORMATION

Section	Details
Patient Information	**Patient Name:** ____ **Maiden Name:** ____ **Sex:** ☐ Male ☐ Female **Date of Birth:** ____ **SSN #** ____ **Street Address:** ____ **City, State, Zip:** ____ **Phone Number:** ____ **Occupation:** ____ **Employer:** ____ **Phone:** ____ **Employer Address:** ____ **Height:** ____ **Weight:** ____ **BMI:** ____ **Referring Physician:** ____ **Phone:** ____
Surgeon Information (Office Use)	**Surgeon Name:** Darin M. Minkin, D.O. **Tax ID #:** 562592570 **Specialty:** General, Laparoscopic & Bariatric Surgery **Office Name:** Darin M. Minkin, D.O. **Office Contact Name:** Ocea **Street Address:** 2355 Dougherty Ferry Road, Suite 430 **City, State, Zip:** St Louis, MO 63122 **Office Phone:** 314-965-8410 **Office Fax:** 314-965-8756 **NPI #:** 1043296494
Procedure Information (Office Use)	**Primary ICD-10 Code:** E66.01 **Secondary ICD-10 Code:** E66.01 **CPT Code 1:** 43770 **CPT Code 2:** S2083 **CPT Code 3:** 43775 **CPT Code 4:** ____ **Site of Service:** ☐ Ambulatory Surgical Center (ASC) ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Physician Office for S2083
Primary Insurance Information	**Insurance Company:** ____ **Street Address:** ____ **City, State, Zip:** ____ **Phone Number:** ____ **Group Plan #** ____ **Policy ID #:** ____ **Policyholder's Name:** ____ **Relationship to Patient:** ____ **Date of Birth:** ____ **Phone:** ____ **Employers Name:** ____ **Surgeon's Participation with Insurer?** ☐ Participating ☐ Non-Participating
Secondary Insurance Information	**Insurance Company:** ____ **Street Address:** ____ **City, State, Zip:** ____ **Phone Number:** ____ **Group Plan #** ____ **Policy ID #:** ____ **Policyholder's Name:** ____ **Relationship to Patient:** ____ **Date of Birth:** ____ **Phone:** ____ **Employers Name:** ____ **Surgeon's Participation with Insurer?** ☐ Participating ☐ Non-Participating

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Darin M. Minkin, D.O. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Darin M. Minkin Inc. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Darin M. Minkin, D.O., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Darin M. Minkin, D.O. Privacy Officer at 2355 Dougherty Ferry Road, Suite 430, St. Louis, MO 63122.

With my consent, Dr. Minkin and staff may call or mail to my home or other designated location and discuss or leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, including but not limited to, appointment reminders, insurance items, calls pertaining to my clinical care, including laboratory results among others and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Darin M. Minkin Inc., use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, Darin M. Minkin, D.O. may decline to provide treatment to me.

Signature of Patient ______________________ Date ______________________

Print Name of Patient ______________________

Signature of Legal Representative or Guardian ______________________ Relationship to Patient or Description of Authority for Patient ______________________

AUTHORIZATION AND PAYMENT AGREEMENT

Dear Valued Patient,

Unless you are a member of an insurance company that is contracted with Dr. Darin M. Minkin, payment for services are expected on the day of the visit. Payment may be made by check, cash, or credit card.

I authorize Darin M. Minkin, Inc. to release any information acquired in the course of my examination or treatment to my insurance company in order to file a claim. I also understand that there may be a balance due from me after my insurance pays their portion. I also authorize payment directly to and assign Darin M. Minkin, D.O. any surgical/medical benefits. A photostatic copy of this release shall be as valid as the original. I understand that if my account is not paid when due, I will be responsible for all cost incurred in the collection process of my account. I further understand that my account will be reported to a credit bureau.

Darin M. Minkin, Inc. does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

Signature of Patient/Responsible Party ______________________ Date ______________________

After receiving an explanation of benefits from your insurance company, we will apply any balance due that is deemed your responsibility automatically to your credit/debit card. First, we will send you a statement for the balance due. If we do not receive payment from you within 15 days or you have not contacted us to make a payment arrangement, we will call and inform you as to what your outstanding balance due is and what day we will be charging your credit card. Therefore, we will require that you provide us with that information below authorizing any future transaction.

If you choose not to sign this authorization, we will require any coinsurance that you are responsible for prior to surgery. For example, if your policy only pays at 80% and you are responsible for 20%, we will require that payment in full unless other arrangements are made up front. If your plan has a deductible, which you have not met, we will not collect that up front as there are many factors that play into how the insurance company processes the claims. If you are unsure of how your insurance policy works, we will be happy to inform you once we contact them about your benefits so you are aware of any deductible or coinsurance you will be responsible for. We apologize if this new policy causes any inconvenience, but we have been forced to take this approach.

If you do not wish to be called prior to your card being charged, please check the box. You will promptly receive a receipt in the mail. ☐

Card Type	☐ Mastercard ☐ Visa ☐ Discover
Cardholder Name:	
Card Number:	
Security Code:	
Expiration Date:	

Signature of Patient/Cardholder ______________________ Date ______________________

Sincerely,

Darin M. Minkin, D.O.

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ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE

Note: If your insurance does not pay for items or services, you will have to pay.

This form is being implemented because the provider has good reason to believe that your insurance company will not cover the services listed below. Our office will bill the insurance company for the services, however, pre-payment is required and will be refunded in the event the insurance company pays for the submitted claims. In the event the insurance company does not pay for the services due to non-coverage denials, please understand that the hospital will also bill you for services listed below at a negotiated cash pay rate that will be discounted to the patient. This is a separate charge for services and the rate is determined by the hospital where services are rendered. The physician's office does not have input on the amounts the hospital charges for services; rates must be determined by the hospital. If pre-payment to the surgeon is not required, understand that you will be responsible for the balance if the insurance company does not cover the services or denies claims for medical necessity. **If the insurance company does pay for services, you will be refunded any payments made to the office less co-pay or deductibles.**

Items or Services:

Procedure Code:	Diagnosis Code:	Amount Billed to Insurance:	Discounted Pre-Pay Rate:

By signing below, you acknowledge that you have read and understand this notice and received a copy.

_______________________________ _______________________________
Signature of Patient/Responsible Party Date

____
Print Name of Patient

PROVIDER-PATIENT VOLUNTARY ARBITRATION AGREEMENT

I. Agreement to Arbitrate.

The parties to this Provider-Patient Voluntary Arbitration Agreement ("Arbitration Agreement") are Darin M. Minkin, D.O. and Darin M. Minkin, Inc., (collectively, the "Provider"), and the Patient named below. It is understood that any dispute as to medical malpractice—that is as to whether any medical services rendered or that were failed to be rendered by the Provider or by any of Provider's agent, employees, associates, staff members, partners, officers, directors, shareholders, proprietors or equity owners to the Patient were unnecessary or unauthorized, were improperly, negligently or incompletely rendered, or the failure to render such services was improper or negligent—will be determined by submission to arbitration binding upon the parties and not by a lawsuit or resort to court or the judicial process except as state law provides for judicial review of arbitration proceedings.

The parties recognize that, in Missouri, there is a right to appeal an arbitration award; however, unless there is evidence of fraud on the part of the arbitrator(s) or a serious procedural defect, an arbitration award pursuant to this Arbitration Agreement would not be overturned and would be a final award. The parties to this Arbitration Agreement, by entering into it, are waiving their constitutional right to have any such dispute decided in a court of law before a jury or before a judge and instead are accepting the use of arbitration as the appropriate and exclusive forum to resolve any dispute or controversy between them.

II. All Claims Must be Arbitrated.

It is the mutual agreement and intention of the parties that this Arbitration Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the Provider, including any spouses or heirs of the Patient, or any others making a claim on the Patient's behalf, and any children, whether born or unborn at the time of the occurrence giving rise to any claim, including where a claim arises due to the treatment of or services provided to any pregnant woman. The term "Patient" herein shall include both the woman patient and the woman's expected child or children. The term "Provider" herein shall include all of Provider's agents, employees, associates, staff members, partners, officers, directors, shareholders, proprietors or equity owners.

The parties mutually agree that they shall submit to binding arbitration all disputes (except actions by the Provider to collect a fee) against each other and their respective agents, partners, associates, officers, directors, shareholders, equity owners, employees, representatives, members, fiduciaries, governing bodies, subsidiaries, parent companies, affiliates, insurers, attorneys, predecessors, estates, successors and assigns, or any of them and all persons, corporations, partnerships or other entities with whom any of the former have been, are now or may be affiliated with at the time of the accrual of the cause of action, for all disputes arising out of or in any way related to or connected with the care and treatment of the Patient provided by the Provider, including but not limited to any disputes concerning alleged personal injury to the Patient caused by improper or inadequate care; allegations of medical malpractice; claims of loss consortium, wrongful death and emotional distress; any disputes concerning whether any statutory provisions relating to the Patient's rights under Missouri law were violated; any claim for punitive damages; and any other dispute under Missouri or federal law based on contract, tort or statute, all of which shall be determined by submission to binding arbitration and not by a lawsuit or resort to judicial process except as state law provides for judicial review of arbitration proceedings. The filing of any action in any

court by the Provider to collect any fee from the Patient shall not waive the right to compel arbitration of any other claim as described above. Following the assertion in court of any claim against the Provider, however, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

III. Procedures and Applicable Law.

A demand for arbitration under this Arbitration Agreement must be communicated in writing to all parties. Each party shall select an arbitrator ("Party Arbitrator") within thirty (30) days of such demand, and a third arbitrator ("Neutral Arbitrator") shall be selected by the appointed Party Arbitrators within sixty (60) days thereafter. In the event the two Party Arbitrators fail to select the Neutral Arbitrator within the sixty (60) day period, a third arbitrator will be appointed from a panel of five arbitrators supplied by Pinnacle Arbitration and Mediation Services, 4232 Forest Park Ave, Saint Louis, Missouri 63108. Within thirty (30) days of the panel of five arbitrators being supplied, the parties will each strike two arbitrators on the panel according to the following procedure and the remaining arbitrator will be the Neutral Arbitrator. First, the Provider will strike one of the arbitrators on the panel; then the Patient will strike one of the remaining four arbitrators on the panel; then the Provider will strike one of the remaining three arbitrators on the panel; finally, the Patient will strike one of the remaining two arbitrators on the panel. Either party shall have the right to request the state circuit court located in the county where the Patient resides or where the Provider's principal place of business is located to appoint a neutral arbitrator in the event that the method provided herein fails, and the court's selection shall be final and binding on the parties.

Each party to the arbitration shall pay one hundred percent (100%) of the expenses and fees of its own Party Arbitrator and fifty percent (50%) of the expenses and fees of the Neutral Arbitrator as well as other expenses and fees of the arbitration, not including its own counsel fees or witness fees or other expenses incurred by a party for such party's own benefit.

The arbitrators shall apply the laws of the State of Missouri, including the applicable statute of limitations and the limitation on damages applicable to medical malpractice cases against health care providers, which is found in Chapter 538 of the Revised Statues of Missouri.

The arbitration hearing will be held before a panel of three (3) arbitrators unless the parties agree otherwise. A decision by the majority of arbitrators hearing the case shall be the final decision of the arbitrators in the arbitration.

Any party to the arbitration as set forth in this Arbitration Agreement may be represented by an attorney of his or her choice at his or her own expense. The arbitrators will hear the facts and reach a decision whether or not the parties are represented by an attorney.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the Neutral Arbitrator. However, all claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding or else waived.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention or joinder, any existing court action against such additional person or entirety shall be stayed pending arbitration.

The arbitration proceeding shall be conducted in accordance with the provisions of Chapter 435 of the Revised Statues of Missouri, as such may be amended from time to time.

All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding or else waived. A claim shall be waived and forever barred if: (1) on the date of notice thereof is received, the claim, is asserted in a civil action, would be barred by the applicable statute of limitations (2) the Patient fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence; or (3) the Patient fails to raise all potential claims from the same incident, transaction or related circumstances to the arbitration proceeding.

IV. Acknowledgements.

Upon signing this Arbitration Agreement submitting to binding arbitration all disputes or controversies arising out of the Provider's services provided to Patient, the Patient hereby acknowledges the following:

The Patient, and/or his or her legal representative, understands that he or she has the right to consult with an attorney of his or her choice before signing this Arbitration Agreement.

The Patient, and/or his or her legal representative, understands, agrees to, and has received a copy of this Arbitration Agreement, has had an opportunity to ask any questions about this Arbitration Agreement and has entered into this Arbitration agreement willingly.

Each party agrees to waive the right to a trial, before a judge or jury, for all disputes (except actions by the Provider to collect a fee) as stated above, subject to the provisions of binding arbitration under this Arbitration Agreement.

This Arbitration Agreement may be revoked by Patient upon written notice delivered to the Provider within thirty (30) days of the Patient's signature date, and if not revoked within that time frame, it will govern all claims regarding medical services involving Patient and Provider.

The Patient, and/or his or her legal representative, acknowledges that he or she has read carefully each provision of this Arbitration Agreement and the Introduction to the Provider-Patient Voluntary Arbitration Agreement and has received a copy of each.

V. Miscellaneous.

The original Arbitration Agreement is to be filed in Patient's medical records.

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

Prior to signing this document, Patient may confer with Provider in order to request any change or modification to the provisions of this document. Patient is encouraged to notify Provider of any provision Patient disagrees with and Patient and Provider may amend any provision in writing which both agree to

change. This Arbitration Agreement contains the entire agreement of the parities with respect to the resolution of disputes between the undersigned Patient and Provider.

If Patient intends this Arbitration Agreement to cover services rendered before the date it is signed (for example, emergency treatment), Patient should initial below.

Effective as of the date of first medical services.

Patient's Initials

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ THIS ARBITRATION AGREEMENT AND UNDERSTANDS THAT BY SINGING THIS ARBITRATION AGREEMENT, EACH HAS WAIVED HIS OR HER RIGHT TO A TRIAL, BEFORE A JUDGE OR A JURY, AND THAT EACH OF THEM VOLUNTARILY CONSENTS TO ALL OF THE TERMS OF THIS ARBITRATION AGREEMENT.

THIS CONTRACT CONTAINS A BINDING ARBTRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

"PROVIDER"
Darin M. Minkin, Inc.

By: ______________________________

Its: ______________________________
Authorized Representative

____
Signature of Physician

____
Print Name of Physician Date

Translated by (if applicable):

____
Signature

____
Print Name Date

"PATIENT"

____
Patient Signature

____
Print Name Date

____
Signature of Patient's Agent/Representative

____
Print Name Date

____
Relationship to Patient

ST. LOUIS BARIATRIC SPECIALISTS, LLC

A New Tool, A New Life.

AGREEMENT

For and in consideration of the medical care and services provided by Dr. Darin M. Minkin, D.O. and the agents, employees, associates, staff members, partners, officers, directors, shareholders, proprietors or equity owners of Darin M. Minkin, Inc. (collectively referred to as the "Provider") to the undersigned, the undersigned agrees that in the event there shall be a claim, dispute or disagreement pertaining to the provision of medical care, or lack of medical care, including any claim of negligence (meaning failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of Provider's profession) by or on behalf of Provider or any agent, employee, associate, staff member, partner, officer, director, shareholder, proprietor or equity owner of Provider, the undersigned agrees that in such event: (i) prior to making any claim against Provider or any person included within the term Provider, the undersigned shall obtain a signed affidavit from a Missouri-licensed medical doctor practicing and board certified in the subspecialty of the medical services which are subject of the claim, stating that the Provider was negligent (as defined above) in providing medical care, and deliver such affidavit to Provider, and (ii) each and every expert witness testifying in any proceeding on the undersigned's behalf shall be a Missouri-licensed medical doctor practicing and board certified in the subspecialty of the medical services which are subject of the claim.

______________________________ ______________________________

Signature of Patient Date

BARIATRIC POST-OPERATIVE INSTRUCTIONS

Upon discharge from the hospital, you are still early in your recuperative period. Full recovery is still weeks away. Your actions during this period are very important to your full and complete recovery. Please follow these instructions and aid us in your quick and total return to full activity.

1. Home is a secure environment……………..You will REST better at home. Take advantage of this…..REST!!!!!!!
2. Pain indicates you might be overdoing it. Avoid activities which cause pain or tenderness.
3. You may use the laxative of your choice, as needed.
4. DO NOT drive until instructed by the doctor following your surgery.
5. Please be sure to get all prescriptions filled and take them as prescribed.
6. Please call the office to schedule your follow-up appointment with the doctor after you are released from the hospital, unless otherwise instructed.
7. DO NOT lift anything over 5-10 pounds!!!!! Lifting anything over 10 pounds will put undue strain on your incision and you risk the possibility of getting an incision hernia. It takes 4-6 weeks for your incision to heal properly.
8. You may shower daily but no tub baths unless you have instructed otherwise.
9. Refrain from sexual relations until after you have had your postoperative appointment with your surgeon.

IF YOU NOTICE ANYTHING UNUSUAL, PLEASE CALL THE OFFICE IMMEDIATELY! PLEASE NOTIFY THE OFFICE IF YOU NOTICE ANY OF THE FOLLOWING:

- FEVER OVER 101 DEGREES
- SIGNS OF INFECTION SUCH AS REDNESS OR EXCESSIVE DRAINAGE AROUND YOUR INCISIONS
- PAIN THAT IS SEVERE
- VOMITING

Your diet and eating habits will be strictly monitored for approximately 6-8 weeks. Foods will be gradually added in a time frame that must be adhered to, both to assure you a full recovery, as well as, your comfort during recuperation. To deviate from the diet will inhibit your healing and possibly cause nausea and/or vomiting, abdominal pain, or esophageal spasms. Direct contact with the office is available Monday through Friday from 9:00 am to 4:00 pm at 314-965-8410. After hours and on weekends, you may reach your surgeon through the answering service by calling 314-865-6000. Please leave a message and they will contact him. If you have an emergency and have not been contacted by your surgeon or the doctor on call for him, go to the emergency room at St. Luke's Des Peres Hospital.

BARIATRIC SURGERY PREOPERATIVE TESTING, CLEARANCE AND EDUCATION REQUIREMENTS

Below Is a list of requirements you will need to complete before you can be scheduled for surgery. The required blood tests must be drawn within 10 days of your surgery date and will be ordered from our office.

The following tests are required and can be scheduled at St. Luke's Des Peres Hospital, after your initial consultation with the surgeon by calling 314-966-9640.

- A psychiatric screening and evaluation by a Psychiatrist or licensed clinical Psychologist. This can be done by your regular Psychiatrist/Psychologist or by one of our staff Psychiatrist who perform many of these evaluations for the Bariatric Program at St. Luke's Des Peres Hospital.
- Bariatric nutritional counseling and evaluation from one of our staff Dietitians.

Please also complete the following requirements:

- Letter of medical clearance from your Primary Care Physician (PCP) as well as current health history and co-morbidities, see form pages 23 & 24.
- An electrocardiogram (ECG) and PA/Lateral chest x-ray must be completed three months prior to surgery.
- The following blood tests must be completed within 10 days from your surgery date: complete blood count (CBC), comprehensive metabolic profile (CMP), thyroid function panel, HCG level (females), prothrombin (PT), partial thromboplastin time (PTT), and internal normalized ration (INR).

The following *may* also be required based on your health status and history:

- If you have a cardiac issue such as congestive heart failure, pacemaker, stent, heart surgery, cardiac catherization or any other heart issue not listed, you will need a letter of cardiac clearance from your regular cardiologist before surgery can be performed.
- Pulmonary clearance: a letter of pulmonary clearance from your Pulmonologist. If full pulmonary function studies are required, they can be completed at St. Luke's Des Peres Hospital and interpreted by our staff Pulmonary Care Specialist.

Once you complete the above testing, educational protocol, and obtain medical clearance requirements, the surgeon will see you again in the office to review the results, the procedure, answer any final question you may have, and schedule your surgery date.

Should you have any questions prior to that, please feel free to contact our office at 314-965-8410.

ST. LOUIS BARIATRIC
SPECIALISTS, LLC
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PCP REQUEST & RECOMMENDATION FORM

Your patient is being evaluated for bariatric surgery and we are requesting the following information as part of our evaluation. Please kindly provide the requested information and complete the form below or on letter head from the treating physician and fax to 314-965-8756. Your assistance is appreciated. Contact us with any questions.

Requirements from PCP:

- Patient current health history and co-morbidities
- ***MEDICARE ONLY-**Two years of your most current office notes (only) documenting co-morbidities

---

Dear Dr. Darin M. Minkin,

I am referring my patient ____ date of birth __________, to you for your opinion regarding the possibility of weight loss options including surgery. The patient's current weight is _______, height is _______, and BMI is _______. The patient has been morbidly obese for ___ years.

The patient's five (5) year weight history is as follows:

1	Year:	2	Year:	3	Year:	4	Year:	5	Year:
	Weight		Weight:		Weight:		Weight:		Weight:

The patient suffers from the following co-morbid conditions associated with morbid obesity which include:

CO-MORBID CONDITIONS (Please check all that apply)			
Type 2 Diabetes-controlled by oral medications	☐	GERD	☐
Type 2 Diabetes-controlled by injectable medications	☐	Heartburn	☐
Obstructive Sleep Apnea	☐	Arthritis	☐
Valvular Heart Disease	☐	History of Medical Non-Compliance	☐
Hypertension	☐	Stress Incontinence	☐
Dyslipidemia	☐	Other- (Please List)	☐

This patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. Please render your opinion on appropriate management options.

Sincerely,

Signature (Required) ____________ Date ____________ Phone: ____________

Printed Name ____________ Address (Required) ____________

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MEDICAL CLEARANCE FOR SURGERY FORM

PATIENT NAME: ____

DATE OF BIRTH: ____________________

THE ABOVE NAMED PATIENT IS SCHEDULED FOR A GENERAL SURGERY PROCEDURE, PLEASE INDICATE IF THE PATIENT:

[ ] IS MEDICALLY CLEARED FOR SURGERY

[ ] IS NOT MEDICALLY CLEARED FOR SURGERY

COMMENTS/ADDITIONAL NOTES: __________________________________

____

____

___________________________	__________	___________________________
PHYSICIAN SIGNATURE	**DATE**	**PHYSICIAN PRINTED NAME:**

PLEASE FAX FORM BACK TO: 314-965-8756

THANK YOU,

ST. LOUIS BARIATRIC SPECIALISTS

CARDIAC CLEARANCE FOR SURGERY FORM

PATIENT NAME: ____

DATE OF BIRTH: ____________________

THE ABOVE NAMED PATIENT IS SCHEDULED FOR A GENERAL SURGERY PROCEDURE, PLEASE INDICATE IF THE PATIENT:

[ ] IS CARDIAC CLEARED FOR SURGERY

[ ] IS NOT CARDIAC CLEARED FOR SURGERY

COMMENTS/ADDITIONAL NOTES: __________________________________

____

____

___________________________	__________	___________________________
PHYSICIAN SIGNATURE	**DATE**	**PHYSICIAN PRINTED NAME:**

PLEASE FAX FORM BACK TO: 314-965-8756

THANK YOU,

ST. LOUIS BARIATRIC SPECIALISTS

ST. LOUIS BARIATRIC
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PULMONARY CLEARANCE FOR SURGERY FORM

PATIENT NAME: ____

DATE OF BIRTH: _____________________

THE ABOVE NAMED PATIENT IS SCHEDULED FOR A GENERAL SURGERY PROCEDURE, PLEASE INDICATE IF THE PATIENT:

[ ] IS PULMONARY CLEARED FOR SURGERY

[ ] IS NOT PULMONARY CLEARED FOR SURGERY

COMMENTS/ADDITIONAL NOTES: ____________________________________

____

____

____________________________	__________	____________________________
PHYSICIAN SIGNATURE	**DATE**	**PHYSICIAN PRINTED NAME:**

PLEASE FAX FORM BACK TO: 314-965-8756

THANK YOU,

ST. LOUIS BARIATRIC SPECIALISTS