



# Bariatric Surgery- Psychological Intake

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_ Mobile Phone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 Marital Status:  Married  Divorced  Separated  Single Never Married  Widowed

How many children do you have? \_\_\_\_\_ Number of children over 18 years of age \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Highest Level of Education Completed: \_\_\_\_\_  
 Major (if applicable): \_\_\_\_\_

List any medical problems for which you are currently receiving treatment:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke? Yes  No  How often? \_\_\_\_\_ How much? \_\_\_\_\_  
 Do you drink alcohol? Yes  No  How often? \_\_\_\_\_ How much? \_\_\_\_\_  
 Do you use drugs other than those prescribed? Yes  No  How often? \_\_\_\_\_ How much? \_\_\_\_\_  
 What kind? \_\_\_\_\_

Which type of Bariatric surgery will you be receiving (select all that apply)  
 Lap Band  Duodenal Switch  Gastric Bypass  Sleeve

How long have you had weight problems? (best guess if you are not sure) \_\_\_\_\_ Number of months: \_\_\_\_\_ Number of years: \_\_\_\_\_  
 Please list the types of diets and exercise programs you have tried in the past (example Jenny Craig, Weight Lifting, Slim Fast)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been able to lose weight in the past? If so, how much? \_\_\_\_\_ lbs Did the weight come back? Yes  No

Please mark any that apply regarding education about the Bariatric Surgery

- I have spoken with a medical professional about the Bariatric Surgery
- I have been given and read a pamphlet with information about the Bariatric Surgery
- I have been given and watched a DVD with information about the Bariatric Surgery
- I have conducted my own online research to learn more about the Bariatric Surgery
- I have attended a seminar about the Bariatric Surgery
- I have been able to talk to someone who currently has had Bariatric Surgery

In the following area, please mark best strengths or a positive traits you possess. **Select up to 5**

- |   |                                     |   |  |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Compassionate    | <input type="checkbox"/> Kind       | <input type="checkbox"/> Gets Along with anyone | <input type="checkbox"/> "People Person" |
| <input type="checkbox"/> Creative         | <input type="checkbox"/> Laid back  | <input type="checkbox"/> Good communicator      | <input type="checkbox"/> Problem solver  |
| <input type="checkbox"/> Dedicated        | <input type="checkbox"/> Loving     | <input type="checkbox"/> Good leader            | <input type="checkbox"/> Resilient       |
| <input type="checkbox"/> Dependable       | <input type="checkbox"/> Loyal      | <input type="checkbox"/> Good listener          | <input type="checkbox"/> Respectful      |
| <input type="checkbox"/> Determined       | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Good teacher           | <input type="checkbox"/> Supportive      |
| <input type="checkbox"/> Self-disciplined | <input type="checkbox"/> Organized  | <input type="checkbox"/> Hard working           | <input type="checkbox"/> Trustworthy     |
| <input type="checkbox"/> Enthusiastic     | <input type="checkbox"/> Outgoing   | <input type="checkbox"/> Helpful                | <input type="checkbox"/> Understanding   |
| <input type="checkbox"/> Generous         | <input type="checkbox"/> Passionate | <input type="checkbox"/> Honest                 | <input type="checkbox"/> Versatile       |
| <input type="checkbox"/> Gentle           | <input type="checkbox"/> Patient    | <input type="checkbox"/> Other _____            |  |

In the following area, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Troubling memories             | <input type="checkbox"/> Unfairly treated by others      |
| <input type="checkbox"/> Depressed mood           | <input type="checkbox"/> Inability to relax             | <input type="checkbox"/> Repetitive behaviors            |
| <input type="checkbox"/> Guilt feelings           | <input type="checkbox"/> Memory difficulties            | <input type="checkbox"/> Drinking or drug problems       |
| <input type="checkbox"/> Over activity            | <input type="checkbox"/> Lack of confidence             | <input type="checkbox"/> Rely too much on others         |
| <input type="checkbox"/> Weight loss              | <input type="checkbox"/> Can't make decisions           | <input type="checkbox"/> Suspicious of others            |
| <input type="checkbox"/> Weight gain              | <input type="checkbox"/> Bitterness or resentment       | <input type="checkbox"/> Recent loss of someone          |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Periods of over activity       | <input type="checkbox"/> Sexual problems/concerns        |
| <input type="checkbox"/> Feelings of inferiority  | <input type="checkbox"/> Eating problems                | <input type="checkbox"/> Family quarreling               |
| <input type="checkbox"/> Loss of interest         | <input type="checkbox"/> Shy or awkward with others     | <input type="checkbox"/> Fearful of things or situations |
| <input type="checkbox"/> Poor sleeping            | <input type="checkbox"/> Unable to trust others         | <input type="checkbox"/> Religious/spiritual concerns    |
| <input type="checkbox"/> Repetitive ideas         | <input type="checkbox"/> Change in eating habits        | <input type="checkbox"/> Cardiovascular /heart problems  |
| <input type="checkbox"/> Thought of suicide       | <input type="checkbox"/> Fighting/arguing with others   | <input type="checkbox"/> Alcohol/drug problem in family  |
| <input type="checkbox"/> Wish to hurt others      | <input type="checkbox"/> Can't stand up for myself      | <input type="checkbox"/> Unusual/strange experiences     |
| <input type="checkbox"/> Marital relationship     | <input type="checkbox"/> Can't say "no" to others       | <input type="checkbox"/> Stress from recent event        |
| <input type="checkbox"/> Financial problems       | <input type="checkbox"/> Poor adjustment to job/school  | <input type="checkbox"/> Divorce/separation difficulty   |
| <input type="checkbox"/> Lonely/too few friends   | <input type="checkbox"/> Bad temper/anger problems      | <input type="checkbox"/> Troubling habits/thoughts       |
| <input type="checkbox"/> Unhappy most of the time | <input type="checkbox"/> Difficulties with opposite sex | <input type="checkbox"/> Feeling rejected by family      |
| <input type="checkbox"/> Problem with children    | <input type="checkbox"/> Stomach or bowel disturbance   | <input type="checkbox"/> Other (specify)                 |

**CURRENT MEDICATION LIST**

Date _____	Patient DOB _____
Patient Name _____	Patient Signature _____
Provider _____	Parent/Guardian Signature _____

<b>Please CLEARLY list any current medications you are taking</b>	<b>Strength</b>	<b>Dose</b>	<b>Frequency</b>
<i>Example- Zithromax Z-Pack</i>	<i>250 mg</i>	<i>1 Pill</i>	<i>2x daily</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list clearly any allergies as it related to medications**

*Example -Penicillin*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

<b>Preferred Pharmacy Name</b> _____	<b>Phone Number</b> _____
_____	<b>Address</b> _____
_____	_____
_____	_____

Primary Care Doctor _____	Fax Number _____
Referring Provider _____	Fax Number _____



Please answer each item either True or False. Note that certain items, if true, can be counted more than once for the total score. If, for example, any one statement occurred more than once to you, please down two (or more) responses for that same question. (Example: 11 *One of my parents probably came from a dysfunctional home.* – indicates the statement applies to both parents)

- 1 I certainly don't need any more hurt in my life
- 2 In my family, we didn't speak freely about our real feelings
- 3 One of my parents probably came from a dysfunctional home (if both, count two)
- 4 I probably came from a dysfunctional home
- 5 There are large portions of my childhood that I simply can't remember
- 6 My parents seemed to have trouble expressing their love to me and rarely did
- 7 My family had definite issues that could not be discussed
- 8 One (or both) of my parents had problems with alcohol or drugs (if both, count two)
- 9 My parents divorced (if more than once, count each event)
- 10 I am divorced (if more than once, count each event)
- 11 I don't feel very good about myself
- 12 If I could avoid relationships, I would
- 13 There has been mental illness diagnosed in my family
- 14 I tried not to think very much about what went on in my family
- 15 Sometimes I cry for no apparent reason
- 16 I don't talk very much about what's really going on inside me
- 17 I'm used to living with confusion
- 18 My spouse died
- 19 My parent(s) is dead. (if both count as two; if stepparent also add one)
- 20 I have been mistreated sexually
- 21 I have been physically and deliberately harmed by someone who supposedly loved me
- 22 A person who supposedly loved me often said some very unkind and cruel things to me
- 23 I lost a child (if more than one, count each event) OR I am infertile
- 24 I lost a sibling (if more than one, count each event)
- 25 I continue to experience sexual difficulties
- 26 I experienced disturbing flashbacks, dreams, or recollections about distressing event(s) or time(s)
- 27 I don't spend nearly enough time with my spouse or family
- 28 I avoid a number of family gatherings
- 29 My eating is not really under control
- 30 I would like to pursue God but I don't seem to do it
- 31 I have experienced an abortion or a miscarriage (if more than one, count each event)
- 32 I have been involved in an adulterous sexual relationship (count one for each relationship)
- 33 My mate has been unfaithful
- 34 I regularly deal with guilt feelings
- 35 I know what it is like to feel depressed rather than just "down" on occasions
- 36 There has been a time where I seriously considered suicide
- 37 Sometimes I feel so terribly lonely and alone
- 38 I have a hard time relaxing
- 39 I must admit that I'm still bitter or resentful about something that happened to me
- 40 I have a hard time really trusting people
- 41 There are times when my anger gets too much out of control for the actual situation
- 42 I'm sometimes afraid for not obvious reason
- 43 I'm no stranger to rejection
- 44 I try very hard to please others
- 45 I have been neglected by someone that was supposed to have loved me

- 46 My sex life is not what it should be
- 47 I have a hard time understanding or communicating what I'm really feeling
- 48 I've experienced too many failures that I just don't understand
- 49 I've been raped/sexually abused (count one per occurrence)
- 50 I have engaged in pornography (score 1-5; if heavily over time, count as five)
- 51 I have reoccurring nightmares of being chased or harmed
- 52 I often prefer the companionship of food to friends
- 53 I witnessed my parent strike a family member (beyond discipline) on more than a few occasions
- 54 One of my parents seemed distant, or not always available, to me (count as two if both)
- 55 I am ashamed of parts of my life
- 56 I avoid conflict whenever possible
- 57 I definitely avoid people in my church, or work, or social situations who have (or may) hurt me
- 58 I have a hard time saying no
- 59 I have gone through periods when I have withdrawn from people for days at a time
- 60 I am not sure that both of my parents loved and accepted me unconditionally
- 61 I really don't know who I am and where I am going with my life
- 62 I don't take very good care of myself
- 63 I must admit that I don't work very hard to grow as a person
- 64 My dad (or mom) was not always there for me (if both, count as two)
- 65 I have used alcohol or drugs in excess (score 1-5; if heavily over time, count as five)
- 66 There are times when I seem to explode at someone who really didn't deserve that degree of anger
- 67 I have been involved with the occult (score 1-5; if heavily, count as five)
- 68 It is hard for me to feel safe in a close relationship
- 69 I seem to punish myself for reasons I don't understand
- 70 Others have told me that I don't see or accept things the way the really are
- 71 I struggle with being really honest about how I feel with people to whom I would like to be able to share myself
- 72 I probably learned some wrong things about God based upon my dad's ability to reflect God to me
- 73 I have been hurt by my church/support system (past or present)
- 74 I usually feel that what I have to offer isn't really good enough
- 75 I'm not really sure just who I am
- 76 I have experienced times where I really felt out of control of my emotions
- 77 I have a hard time sleeping through the night
- 78 Sometimes I get so nervous, worried, or panicked that I alarm myself (count one per panic event)
- 79 Sometimes my thoughts seem to be way out of control
- 80 There are times that I know I have flagrantly lost contact with reality (count five per event)

**Scoring directions: Count each true answer as one point (plus additional points from specific items as instructed).**

**80B** Over the past 12 months I have experienced a crisis, traumatic event, loss of a loved one, or a lifestyle change

**Note: any one area or crisis alone, if prolonged and/or intensive enough, could create significant woundedness suggesting intensive psychotherapy or medical management.**

**Key:**

<b>20 or less</b>	<b>=</b>	<b>Mild woundedness</b>
<b>21-30</b>	<b>=</b>	<b>Moderate woundedness</b>
<b>31-40</b>	<b>=</b>	<b>Significant woundedness</b>
<b>41-50</b>	<b>=</b>	<b>Severe woundedness</b>
<b>60 or more</b>	<b>=</b>	<b>Extreme woundedness</b>

**Name:** \_\_\_\_\_ **I.D.#:** \_\_\_\_\_ **Score:** \_\_\_\_\_



Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) use of prescribed or "or over the counter" drugs in excess of the directions, and (2) any non-medical use of drugs. This includes recreational or illegal use, or substances used without your doctors' knowledge. Prescribed medication used properly does not apply. Considers the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

Table with 28 numbered questions and two columns for YES and NO responses.

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Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5,and 7, which NO response is given a score of "1". Based on data from a heterogeneous psychiatric population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately the patients that do not have a substance abuse disorder. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16 ,20, and 22.



Name: \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

This questionnaire consists of 21 groups of statements with a rating of 0-3 for each. Please circle the number that BEST describes how you have been feeling in the **past week, including today**. If several statements within a group seem to equally apply, circle each one. Be sure to read all the statements in each group before making your choices. Calculate the sum of the circled statement's numerical value in the total score area below.

- 1 0 I do not feel sad.  
1 I feel sad  
2 I am sad all the time and I can't snap out of it.  
3 I am so sad and unhappy that I can't stand it.
- 2 0 I am not particularly discouraged about the future.  
1 I feel discouraged about the future.  
2 I feel I have nothing to look forward to.  
3 I feel the future is hopeless and that things cannot improve.
- 3 0 I do not feel like a failure.  
1 I feel I have failed more than the average person.  
2 As I look back on my life, all I can see is a lot of failures.  
3 I feel I am a complete failure as a person.
- 4 0 I get as much satisfaction out of things as I used to.  
1 I don't enjoy things the way I used to.  
2 I don't get real satisfaction out of anything anymore.  
3 I am dissatisfied or bored with everything.
- 5 0 I don't feel particularly guilty  
1 I feel guilty a good part of the time.  
2 I feel quite guilty most of the time.  
3 I feel guilty all of the time.
- 6 0 I don't feel I am being punished.  
1 I feel I may be punished.  
2 I expect to be punished.  
3 I feel I am being punished.
- 7 0 I don't feel disappointed in myself.  
1 I am disappointed in myself.  
2 I am disgusted with myself.  
3 I hate myself.
- 8 0 I don't feel I am any worse than anybody else.  
1 I am critical of myself for my weaknesses or mistakes.  
2 I blame myself all the time for my faults.  
3 I blame myself for everything bad that happens.
- 9 0 I don't have any thoughts of killing myself.  
1 I have thoughts of killing myself, but I would not carry them out.  
2 I would like to kill myself.  
3 I would kill myself if I had the chance.
- 10 0 I don't cry any more than usual.  
1 I cry more now than I used to.  
2 I cry all the time now.  
3 I used to be able to cry, but now I can't cry even though I want to.
- 11 0 I am no more irritated by things than I ever was.  
1 I am slightly more irritated now than usual.  
2 I am quite annoyed or irritated a good deal of the time.  
3 I feel irritated all the time.

- 12 0 I have not lost interest in other people.  
 1 I am less interested in other people than I used to be.  
 2 I have lost most of my interest in other people.  
 3 I have lost all of my interest in other people.
- 13 0 I make decisions about as well as I ever could.  
 1 I put off making decisions more than I used to.  
 2 I have greater difficulty in making decisions more than I used to.  
 3 I can't make decisions at all anymore.
- 14 0 I don't feel that I look any worse than I used to.  
 1 I am worried that I am looking old or unattractive.  
 2 I feel there are permanent changes in my appearance that make me look unattractive  
 3 I believe that I look ugly.
- 15 0 I can work about as well as before.  
 1 It takes an extra effort to get started at doing something.  
 2 I have to push myself very hard to do anything.  
 3 I can't do any work at all.
- 16 0 I can sleep as well as usual.  
 1 I don't sleep as well as I used to.  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
- 17 0 I don't get more tired than usual.  
 1 I get tired more easily than I used to.  
 2 I get tired from doing almost anything.  
 3 I am too tired to do anything.
- 18 0 My appetite is no worse than usual.  
 1 My appetite is not as good as it used to be.  
 2 My appetite is much worse now.  
 3 I have no appetite at all anymore.
- 19 0 I haven't lost much weight, if any, lately.  
 1 I have lost more than five pounds.  
 2 I have lost more than ten pounds.  
 3 I have lost more than fifteen pounds.
- 20 0 I am no more worried about my health than usual.  
 1 I am worried about physical problems like aches, pains, upset stomach, or constipation  
 2 I am very worried about physical problems and it's hard to think of much else.  
 3 I am so worried about my physical problems that I cannot think of anything else.
- 21 0 I have not noticed any recent change in my interest in sex.  
 1 I am less interested in sex than I used to be.  
 2 I have almost no interest in sex.  
 3 I have lost interest in sex completely.

**TOTAL  
SCORE**

1-10	These ups and downs are considered normal	21-30	Moderate depression
11-16	Mild mood disturbance	31-40	Severe depression
17-20	Borderline clinical depression	Over 40	Extreme depression



**Barnabas Behavioral Healthcare LLC**  
**Notice of Privacy Practices**

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

**General Information**

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320det seq., 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Barnabas Behavioral Healthcare LLC may not say to a person outside Barnabas Behavioral Healthcare LLC that you attend the practice, nor may Barnabas Behavioral Healthcare LLC disclose any information identifying you as a client, or disclose any other protected information except as permitted by federal law.

Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Barnabas Behavioral Healthcare LLC can share information for treatment purposes or for health care operations. However, federal law permits Barnabas Behavioral Healthcare LLC to disclose information without your written permission in the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Barnabas Behavioral Healthcare LLC premises or against Barnabas Behavioral Healthcare LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect or domestic violence.
6. As allowed by a court order.

For example, Barnabas Behavioral Healthcare LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Barnabas Behavioral Healthcare LLC may need to share your protected health information with third party "business associates" that perform various activities such as laboratory services and billing partners. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Before Barnabas Behavioral Healthcare LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing at any time.

**Your Rights:**

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. At your request, Barnabas Behavioral Healthcare LLC will not disclose information to your health insurance plan about any services for which you have paid out-of-pocket. Barnabas Behavioral Healthcare LLC is not required to agree to any other restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location.

Barnabas Behavioral Healthcare LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Barnabas Behavioral Healthcare LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Barnabas Behavioral Healthcare LLC records, and to request and receive an accounting of disclosures of your health related

information made by Barnabas Behavioral Healthcare LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

**Barnabas Behavioral Healthcare LLC Duties:**

**Barnabas Behavioral Healthcare LLC will not share your protected health information for marketing or fundraising purposes, nor will we ever sell your protected health information without your prior approval.**

**Barnabas Behavioral Healthcare LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Barnabas Behavioral Healthcare LLC is required by law to abide by the terms of this notice. Barnabas Behavioral Healthcare LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. You may access a revised version by accessing our website, or you may request a copy by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.**

**Questions and Complaints:**

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer Peter Zaepfel at 803-216-0850.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Peter Zaepfel, Corporate Compliance Officer Telephone: 803-216-0850 Fax: 803-216-0420

Address: 409 Evelyn Drive Columbia, South Carolina 29210

## Acknowledgement of Receipt of Privacy Practices

I have read, understood, and received a copy of Barnabas Behavioral Healthcare LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Authorization to Disclose Information**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will expire 12 months after first signed.

\_\_\_\_\_ I want this information released to my Referring Doctor (Doctor who is doing your Bariatric Surgery trial)

\_\_\_\_\_ I DO NOT want this information released to my Referring Doctor

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



Barnabas Behavioral Healthcare, LLC  
**Consent to Treatment**

I \_\_\_\_\_ (patient name) give permission for **Barnabas Behavioral Healthcare, LLC** to give me psychological treatment/ assessments/ testing/ screenings/ medical treatment. I allow **Barnabas Behavioral Healthcare, LLC** to file for insurance benefits to pay for the care I receive and I am responsible for prompt payment for my portion of my bill should I not have insurance or it is determined by my insurance company to be "patient responsible".

I understand that:

**Barnabas Behavioral Healthcare, LLC** will have to send my medical record information to my insurance company.

I must pay my share of the costs.

I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

An assessment letter will be sent to my referring provider with the result of my assessment

I understand:

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

I can cancel my appointment outside of 24 business hours without incurring a no-show charge (business hours are M-F 8AM-5PM)

It is my responsibility to remember my appointment date and time and it is only a courtesy for me to receive a reminder call, email, or text.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_