MALLADI
BARIATRICS AND ADVANCED SURGERY

Preeti Malladi, M.D. P.A.

221 W. Colorado Blvd, Ste 829 Pavilion II, Dallas, TX 75208
4100 W. 15th St. Ste. 216, Plano, TX 75093
Phone 214-242-9737
Fax 214-242-9946

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____ Phone #: _____

Dr. Malladi will need your pharmacy number to call in prescriptions.

Thank you for selecting Dr. Malladi to assist in meeting your surgical and/or weight management needs. To save time please complete all of the forms included in this package prior to your consultation. As a friendly reminder, don't forget to bring your photo ID and insurance card(s) along with your copay. A list of all medications you are currently taking complete with the dosage and times taken is required. Please arrive 15 minutes prior to your scheduled appointment time.

If you are unable to keep your appointment contact us at (214) 242-9737, between the hours of 8:30 am and 4:30 pm, Monday – Friday.

Please read and acknowledge the following:

We advise that you take time prior to you initial examination to call your insurance carrier and confirm that Dr. Malladi is a participating provider with your plan and to confirm what services will or will not be covered. This may save you unexpected medical charges.

I understand that some insurance companies do not cover all charges that may be incurred during my treatment. I also recognize that I am financially responsible for any part of the charges not paid for by my insurance company.

Please do not hesitate to contact our office with any questions or concerns regarding your treatment.

Dr. Malladi and her team are looking forward to meeting you and serving your medical and surgical needs.

_____ _____

Patient Signature Date

For Patient's Coming to the Dallas Office, Parking is Available in Pavilion II Parking Garage

Patient Profile

PATIENT INFORMATION

Patient's Name: _____ Referred By: _____

Address: _____ _____ _____ _____

Street Apt# City State Zip

Hm# _____ Cell#_____

Wk#_____ Email Address: _____

SS# _____ SEX: ☐ Female ☐ Male DOB: ____/_____/_____

Language: _____ Ethnicity: _____ Race: _____

Employer: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Domestic Partner
Spouse's Name (if applicable): _____

FINANCIAL/INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Name of Insured: _____ DOB: _____ /_____/_____ SSN: _____

ID#: _____ Group#: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance: YES ☐ NO ☐ If yes, Insurance Company: _____

Name of Insured _____ DOB: _____ /_____/_____ SSN: _____

ID#: _____ Group#: _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS/FINANCIAL OBLIGATION

We will be happy to file your charges to the insurance carrier you have provided us. You are responsible for copays, deductible, co-insurance, and any charges deemed as not covered by your carrier. Payment for your patient share is due on or before the service is provided. For your convenience we accept MasterCard, Visa, Discover, cash and personal checks (under $100). A $30 fee is assessed for returned checks. We will only use your Email for non-clinical contact, i.e. billing questions or comments.

I understand that I am responsible for all charges incurred for my medical treatment. This includes an assistant surgeon, which may be required for some procedures. I authorize payment of all my medical benefits to my healthcare provider. In addition, I authorize my healthcare provider to release information to my insurance company.

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X_____ _____

Signature of patient or authorized person Date

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

Reason for Visit: _____

Primary Care Physician: _____ Phone: _____

Past Medical History:

Have you ever had any of the following?

Diabetes	YES	NO	Acid Reflux/heartburn	YES	NO	Stomach Ulcer	YES	NO
High Blood Pressure	YES	NO	Depression	YES	NO	Kidney Disease	YES	NO
High Cholesterol	YES	NO	Other Psych disorders	YES	NO	AIDS or HIV+	YES	NO
Heart Disease	YES	NO	Thyroid Disease	YES	NO	Bleeding Tendency	YES	NO
History of heart attack	YES	NO	Stroke	YES	NO	Mitral Valve Prolapse	YES	NO
Sleep Apnea	YES	NO	Hepatitis	YES	NO	Liver Disease	YES	NO
Osteoarthritis	YES	NO	Asthma	YES	NO	Cancer	YES	NO
Blood clots in legs /lungs	YES	NO	Tuberculosis	YES	NO	Other:_____		

List of Allergies/Reaction: _____Objection to the use of blood or blood products: YES NO

Medications (including nonprescription)	Strength/frequency	Surgeries

List Major Illnesses/Hospitalizations (use back if necessary): _____

For bariatric patients: How long have you struggled with being overweight? _____ What types of programs have you tried to lose weight? How successful?_____Describe your current diet:_____ Describe your current activity level:_____ _____ Any family/friends have weight loss surgery? _____

Why do you want to lose weight?_____ How long have you considered surgery? _____

Social History

Children: YES or NO If yes, how many children: ____ **Smoking: Do you smoke?:** YES or NO Type:_____

Packs per day:_____ If former smoker, date quit: _____ **Does anyone in your home smoke**?: YES NO Who smokes:_____

Do you use the following: Tobacco:_____ Alcohol: None Occasional Moderate Excessive

Drug Use: _____

Family History:

Has any blood relative ever had any of the following?

Breast Cancer	YES	NO	High Blood Pressure	YES	NO	Kidney Disease	YES	NO
Obesity	YES	NO	Heart Disease	YES	NO	Depression	YES	NO
Stroke	YES	NO	Diabetes	YES	NO	Other Cancers	YES	NO
Seizures	YES	NO	Blood clotting disorders	YES	NO			

Cancer Screening History:

Date of last Colonoscopy: _____ NORMAL ABNORMAL

WOMEN ONLY: Date of last Mammogram: _____ NORMAL ABNORMAL

Start date of last menstrual cycle (if applicable): _____ Date of last PAP Smear:_____ NORMAL ABNORMAL

MEN ONLY: Date of last prostate screening:_____ NORMAL ABNORMAL

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I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Sign:_____ Date of birth:_____

SYSTEMS REVIEW

CONSTITUTIONAL	YES	NO
Recent change in weight	❑	❑
How many pounds?		
Gained: _____		
Lost: _____		
Since when? _____		
Loss of appetite	❑	❑
Fever	❑	❑
Fatigue	❑	❑
Night sweats	❑	❑
HEAD		
Frequent headaches	❑	❑
Seizures	❑	❑
Head injury	❑	❑
(If yes, when? ____/____/____)		
EYES		
Trouble with vision	❑	❑
Wear corrective lenses	❑	❑
EARS, NOSE, AND THROAT		
Trouble hearing	❑	❑
Hoarse voice	❑	❑
GASTROINTESTINAL		
Heartburn	❑	❑
Feel bloated after eating	❑	❑
Have difficulty swallowing	❑	❑
Nausea and vomiting	❑	❑
Have vomited blood	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Black stools	❑	❑
Hemorrhoids	❑	❑
Rectal bleeding	❑	❑
Have pain in stomach	❑	❑
After eating?	❑	❑
Have pain elsewhere		
In abdomen	❑	❑
GENITO-URINARY		
Burning with urination	❑	❑
Blood in urine	❑	❑
MUSCULOSKELETAL		
Stiff or painful joints	❑	❑
Muscle pain	❑	❑

RESPIRATORY	YES	NO
Shortness of breath	❑	❑
Coughing	❑	❑
Coughing up blood	❑	❑
Wheezing	❑	❑
Bronchitis more than once per month	❑	❑
CARDIOVASCULAR		
Chest pain, or tightness	❑	❑
Difficulty in breathing	❑	❑
Heart palpitations	❑	❑
Had Stress Test	❑	❑
(If yes, when? ____/____/____)		
SKIN		
Changes in coloration of your skin	❑	❑
Any lumps noticed:		
Under your arms?	❑	❑
Groin area?	❑	❑
Breast?	❑	❑
NEUROLOGIC		
Convulsions	❑	❑
Muscular weakness	❑	❑
Paralysis	❑	❑
Any loss of sensation, tingling, numbness, in your fingers, toes, limbs?	❑	❑
MOOD		
Depressed?	❑	❑
Anxious?	❑	❑
Trouble sleeping?	❑	❑
ENDOCRINE		
Diabetes	❑	❑
Hypoglycemia	❑	❑
Hyperthyroid	❑	❑
Hypothyroid	❑	❑
Goiter/Thyroid surgery	❑	❑
Heat/cold intolerance	❑	❑
Chronic steroid use	❑	❑
Other Endocrine problems:_____		

HEMATO/LYMPH	YES	NO
Anemia	❑	❑
Hemophilia	❑	❑
Daily Aspirin	❑	❑
Sickle Cell Disease	❑	❑
Enlarged lymph node	❑	❑
Clotting problems	❑	❑
Easy bruising	❑	❑
Other blood/lymph gland problems:_____		
ALLERGY/IMMUNE		
Autoimmune disorder	❑	❑
Immune deficiency	❑	❑
Plant/animal allergy	❑	❑
AIDS/HIV	❑	❑
Other allergy/immune problems:_____		
SLEEP		
Snoring	❑	❑
Sleep Apnea	❑	❑
(Do you use CPAP?)	❑	❑
Date of last sleep study? ____/____/____		

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Completion of Medical ~ Leave of Absence Forms

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There is a $25 fee for the **initial** completion of disability or medical leave absence forms including Family Medical Leave Act (FMLA). There is an additional $15 fee for the completion of **any** subsequent forms to extend your leave of absence **per occurrence**. The fee is applicable for each individual. Please keep in mind that we require a minimum of 7 business days for the completion of the forms. It is imperative that you provide your form(s) to our office as quickly as possible to avoid any delays with your employer or insurance company.

_____ initials

Cancellation Policy

Every appointment is a reservation of time that you have requested to provide your necessary medical care.
We ask that if you find it is necessary to reschedule your appointment, that you give us a minimum of 24 hour notice to avoid a cancellation fee. A fee of $25 will be charged for all cancellations or missed appointments that occur with less than 24 hour notice. A $100 fee will be charged for all cancellations or missed procedures that occur with less than 24 hour notice.

_____ initials

PATIENT CONSENT FORM/HIPAA STATEMENT

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You also acknowledge that you have been given the opportunity to review our office HIPAA statement. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent. I acknowledge that I have read and understand the policies listed above.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

Patient refused to sign: _____ Patient took home for review: _____

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to family and friends. Is there anyone that we can give information to? If so, please specify:

Name(s):_____ Relationship:_____

Dr. Malladi has ownership interest in Medical City Surgical Center Park Central. I understand that I might be referred to this facility for service and that I may speak with my physician about her financial relationship with the facility. I understand that I can ask that services be provided at a facility where there is no ownership interest.

Signature:_____ Date:_____

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Preeti Malladi, M.D.
221 W. Colorado Blvd #829
Dallas, TX 75208
214-242-9737

We would like to thank you for making an appointment with our office. It is important that you understand the procedures of our office regarding **Bariatric or General Surgery**.

You are responsible for getting referrals and keeping them updated with our office. All records requests from other physicians and any other records required for the approval process.

- You must pay any copays, deductibles or deposits **PRIOR** to scheduling a surgery date. Should you need to pay out your deposit, we are happy to accept those payments. Please be advised that surgery will not be scheduled until your entire deposit is paid in full. There will be a NO SHOW charge of $100 if you NO SHOW for your surgery. A card on file is required. **We do not offer payment arrangements.**
- Please note: We accept cashier checks, cash and credit cards. **We do not accept personal checks over $100**. After surgery has been performed and the insurance has paid if there is a refund due to you on your account we will gladly issue a refund from our office please be advised that if your deposit was paid with a credit card/bank card we will charge a 3% processing fee in order to cover the charges associated with processing your credit card payment. A $30 fee will be assessed for any returned check.

Please read carefully and sign acknowledgement:

- I hearby authorize Preeti Malladi, M.D. to furnish medical records and/or test results including HIV status, via fax or mail, to my referring doctor, insurance companies and to the doctor to whom I am referred concerning my illness or treatment. I will not hold Preeti Malladi, M.D. or her employees responsible for any misdirected records or correspondence.
- I hearby certify that I have provided Preeti Malladi, M.D. my current insurance, address, phone numbers and any other pertinent information. I also understand that failing to disclose this information could result in my insurance carrier not providing benefits for this service.
- If for any reason you decide to cancel your surgery, please inform us as soon as possible so that we may schedule another patient. Failure to notify the office of a cancellation at least 48 hours in advance will result in a $100 cancellation fee.

Patient Signature:_____ **Date:**_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize _____, or its agents, to disclose information from the medical record of:

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security #: _____

To: Preeti Malladi, MD PA
Malladi Bariatric and Advanced Surgery
221 W. Colorado Blvd, Pavilion II, Ste. 829
Dallas, Texas 75208
Phone: 214-242-9737 Fax: 214-242-9946

Please release the following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Medication Lists
_____ List of Allergies
_____ Demographic/Insurance
_____ All Medical Records

_____ X-Ray/Imaging reports from (date) _____ to _____
_____ X-Ray Films
_____ Lab results from (date) _____ to _____
_____ EKG Reports
_____ Pathology Reports
_____ Other Diagnostic Reports (Specify) _____
_____ Records from _____ to present only.

Other: _____

For the purpose of: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ YES, I consent to the release of this information. _____ NO, I do not consent to the release of this information.

I understand that the information release is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, a provided in CFR 166.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact our Office Manager.

Signature of Patient or Legal Representative: _____ Date: _____
Relationship to Patient: _____ Witness: _____

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Phone 214-242-9737 Fax 214-242-9946
NPI: 1982873220 TID: 27-0728490

Communication by Email Authorization

Our office offers patient communication by email. This form provides information about the risks of emails, guidelines for email communication, and how we use email communication. It also will be used to document your consent for communication with you by email.

Communication by email has a number of risks, which include the following:

- Can be circulated, forwarded and stored in paper and electronic files
- Backup copies of emails may exist even if the file has been deleted
- Can be received by unintended recipients
- Can be intercepted, altered forwarded or used without authorization or detection
- Senders can easily type the wrong email address
- Can be used to introduce viruses into the computer system

How we will use email: We will email correspondence to established patients who are 18 years or older, or the legal representative of established patients. We use email to communicate only about non-sensitive and non-urgent issues. All emails to or from you will be made a part of your medical record. You have the same right of access to such emails as you do to the remainder of your medical record. Your email message may be forwarded to another office staff member as necessary for appropriate handling. We will not disclose your emails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permit uses of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911. Do not email for urgent problems. Emails should not be time-sensitive. While we try to respond to email messages daily, **it may take up to three (3) working days** for us to respond to your message. Urgent messages or needs should be relayed to us by using regular telephone communication. If you have not heard back from us within three days, call our office to follow up if we have received your email.

I have elected to communicate with Dr. Preeti Malladi's office staff by email. I understand the risk of communicating by email, in particular the privacy risks explained in this form. I understand that they cannot guarantee the security and confidentiality of email communication. They cannot be responsible for messages that are received or delivered due to technical failure, or for disclosure of confidential information not caused by intentional misconduct. I understand that I may also communicate with the doctor and/or office by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information. I understand that I may revoke this consent at any time by so advising Dr. Preeti Malladi's office staff in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for email communication to and from Dr. Preeti Malladi and office staff.

Patient Name:_____ Date:_____

Signature:_____ Email:_____