REGISTRO

(POR FAVOR, ESCRIBA EN LETRA DE IMPRENTA)

CROWN SURGICAL GROUP
802 Magnolia Ave., Suite 203
Corona, CA 92879

Telephone: (909) 736-0696

Fecha________________ Teléfono Personal________________

INFORMACION SOBRE EL PACIENTE

Nombre________________ No. Seg. Soc.________________
Apellido Primer Nombre Inicial

Dirección________________

Ciudad________________ Estado________________ Código Postal________________

Sexo ☐ M ☐ F Edad________ Fecha de Nacimiento________________ ☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Divorciado(a)

Paciente Empleado por________________ Ocupación________________

Dirección del Empleador________________ Teléfono del Empleador________________

¿A quién podemos agradecer por habernos referido a Ud?________________

En caso de emergencia, ¿a quién se deberá notificar?________________ Teléfono________________

SEGURO PRINCIPAL

Persona Responsable por la Cuenta________________
Apellido Primer Nombre Inicial

Relación con el Paciente________________ Fecha de Nacimiento________________ No. Seg. Soc.________________

Dirección (Si es diferente a la del paciente)________________ Teléfono________________

Ciudad________________ Estado________________ Código Postal________________

Persona Responsable Empleada por________________ Ocupación________________

Dirección del Empleador________________ Teléfono del Empleador________________

Compañía de Seguros________________

Contrato No.________________ Grupo No.________________ Suscriptor No.________________

Nombres de otras personas a su cargo cubiertas por este plan________________

SEGURO ADICIONAL

¿Está el paciente cubierto por seguro adicional? ☐ Sí ☐ No

Nombre del Suscriptor________________ Relación con el Paciente________________ Fecha de Nacimiento________________

Dirección (Si es diferente a la del paciente)________________ Teléfono________________

Ciudad________________ Estado________________ Código Postal________________

Suscriptor Empleado por________________ Teléfono del Empleador________________

Compañía de Seguros________________ No. Seg. Soc.________________

Contrato No.________________ Grupo No.________________ Suscriptor No.________________

Nombres de otras personas a su cargo cubiertas por este plan________________

TRASPASO DE LOS BENEFICIOS DEL SEGURO Y AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN

Yo, el suscrito, certifico que yo (o la persona a mi cargo), tengo (tiene) cobertura de seguro con________________
Nombre de la(s) Compañía(s) de Seguros

y traspaso directamente al Dr. ________________ todos los beneficios del seguro, si los hubiere, que de otra manera son pagaderos a mí, por servicios prestados. Yo entiendo que soy financieramente responsable por todos los cargos incurridos, ya sea que son pagados por el seguro o no. Por el presente yo autorizo al doctor a divulgar toda la información que sea necesaria para asegurar el pago de los beneficios. Yo autorizo el uso de esta firma en todas las presentaciones que se hagan ante el seguro.

________________ ________________ ________________
Firma de la Persona Responsable Relación Fecha

#10567 – Medical Arts Press 1-800-328-2179

HISTORY AND PHYSICAL (HISTORIA DEL PACIENTE)

NAME / NOMBRE____________ AGE / EDAD______ DATE/FECHA________

PRESENT WEIGHT/ PESO ________ LBS HEIGHT / ESTATURA________

MEDICAL REASON FOR VISIT / RAZON MEDICA DE SI VISITA________

ALLERGIES/SENSITIVITIES TO MEDICATIONS / ALERGIAS/SENSIBILIDADES A MEDICINAS________

PATIENT'S MEDICAL HISTORY:(CIRCLE YES OR NO) / HISTORIA MEDICA DEL PACIENTE (CIRCULE EL SI O EL NO)

Y / N HEART ATTACK (ATAQUE AL CORAZON)
WHEN (CUANDO)________?

Y / N HEART FAILURE (PARO CARDIACO)

WHEN (CUANDO)________?

Y / N HEART MURMUR (MURMULLO DEL CORAZON)

Y / N PROSTATE PROBLEMS (PROSTATA FIEBRE REUMATICA)
Y / N RHEUMATIC FEVER (FIEBRE REUMATICA)
Y / N HYPERTENSION (PRENSION ALTA)
Y / N HEPATITIS (HEPATITIS)
Y / N ASTHMA (ASMA)

Y / N JAUNDICE (ICTERICIA)
Y / N KIDNEY DISEASE (RINONES)
Y / N TUBERCULOSIS (TUBERCULOSIS)
Y / N PHLEBITIS (BLOOD CLOT IN LEG) (FLEBITIS)
Y / N DIABETES (DIABETIS)
INSULIN TYPE / AMOUNT (TIPO DE INSULINA CANTIDAD)

____

Y / N THYROID PROBLEMS (TIROYDE)
Y / N COLITIS/COLON PROBLEMS (COLITIS/POLYPOS)
Y / N ULCER DISEASE (ULCERAS)
Y / N CANCER
WHAT TYPE (QUE TIPO)________?

LIST ANY ILLNESSES YOU HAVE BEEN HOSPITALIZED FOR, NOT REQUIRING SURGERY (ENFERMEDADES POR LAS CUALES HA SIDO HOSPITALIZADO, SIN REQERIR CIRUGIA)

PREVIOUS SURGERIES AND APPROXIMATE DATES (CIRUGIAS Y FECHAS APROXIMADAS)

ANY FAMILY HISTORY:(CIRCLE YES OR NO) / HISTORIA MEDICA DEL PACIENTE (CIRCULE EL SI O EL NO)

Y / N DIABETES (DIABETIS)
Y / N BLEEDING TENDENCIES
Y / N KIDNEY DISEASE (RINONES)
Y / N TUBERCULOSIS (TUBERCULOSIS)

Y / N STROKE (TROMBOSIS)
Y / N HIGH BLOOD PRESSURE (ALTA PRESION)
Y / N HEART DISEASE (ENFERMEDAD DEL CORAZON)
Y / N CANCER
WHAT TYPE (QUE TIPO)________?

MEDICATIONS (MEDICAMENTOS)

PRESCRIPTION (CON RECETA MEDICA)________

NON-PRESCRIPTION (SIN RECETA MEDICA)________

BLOOD THINNERS (DILUYENTE DE LA SANGRE)________

DO YOU USE TOBACCO?(USO DE TABACO)________ IN THE PAST? (EN EL PASADO)______

DO YOU USE ALCOHOL?(USO DE ALCOHOL) ________ AVG DAILY AMOUNT?(CANTIDAD DIARIA)______

CROWN SURGICAL GROUP

Raymund Cordero, M.D.
Francis Essien, M.D.
Yara Gorski, M.D.
Bolaji Nafiu, M.D.

Festus Dada, M.D.
Tito Gorski, M.D.
David Suh, M.D.
Craig Owens, M.D.

COMMUNICATION CONSENT AGREEMENT

This form allows our physicians and office staff permission to speak with your family members or other individuals noted below.

I, _____________________________________ understand that under Federal Law (HIPPA) this medical office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Crown Surgical Group to release medical information on my behalf to the following person(s).

(1) Name: ____________________________________ **Relationship:** __________________

Phone Number: ________________________________ **Date of Birth:** __________________

(2) Name: ____________________________________ **Relationship:** __________________

Phone Number: ________________________________ **Date of Birth:** __________________

(3) Name: ____________________________________ **Relationship:** __________________

Phone Number: ________________________________ **Date of Birth:** __________________

(4) Name: ____________________________________ **Relationship:** __________________

Phone Number: ________________________________ **Date of Birth:** __________________

PATIENT NAME: ___________________________________ ***DATE OF BIRTH:*** ________

PATIENT SIGNATURE: _______________________________ ***DATE:*** ________________

800 Magnolia Avenue Suite 107
Corona, CA 92879
(951) 736-0696

Crown Surgery Medical Group

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Crown Surgery Medical Group** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Crown Surgery Medical Group** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Crown Surgery Medical Group** 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 **Privacy Officer, 25470 Medical Center Drive Murrieta, Ca. 92562**

With this consent, **Crown Surgery Medical Group** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Crown Surgery Medical Group** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Crown Surgery Medical Group** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Crown Surgery Medical Group** to restrict how it uses or discloses my PHI to carry out TPO. 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 allow **Crown Surgery Medical Group** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Crown Surgery Medical Group** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________ ____________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

CROWN BARIATRIC SURGICAL GROUP

Date ________________

HISTORY & PHYSICAL

Patient: ________________________ Birth Date: __________ Spouse: _____________

Address: _______________________ City: ______________ Zip Code: ___________

Phone: ________________

Referred By: _______________ Employer: ________________ Occupation: _________

Primary Insurance: ___________________ Secondary Insurance: __________________

____________________________ ________________________ __________________
Name of Primary Care Physician   Phone Number   Fax Number

____________________________ ________________________ ______ ___________
Address   City   State   Zip Code

SURGEON'S NOTES

Date of Exam: _________________

First time obesity noted: ____________ Age: _____ Weight: _____ Maximum Wt: ____

*** Signed: ______________________________ *** Date Dictated: _______________

REVIEW OF CO-MORBID CONDITIONS

Please Complete In Detail

___ **Sleep Apnea:** ____ Snoring ____ Chocking
How Often Awake at Night ____ Require C-Pap: No ___ Yes ___

___ **Hypertension:** Highest B/P: _____ Current B/P: _____ Take Meds: __ Yes __ No

___ **Diabetes:** Age of Onset ___ Physician: ____________ Control: Good ___ Poor ___

___ **Pain of Wt Bearing Joints**: Back ___ Hips ___ Knees ___ Feet ___
Exercise Limitations: Mild ___ Moderate ___ Severe ___

___ **Pulmonary Disease**: Short of Breath on Exertion: ___ Emphysema/COPD: ___
Hayfever/Allergies: ___ Asthma: ___ Age Onset: ____

___ **CardioVascular:**

CHF	Yes ___	No ___	Varicose Veins	Yes ___	No ___
Heart Disease	Yes ___	No ___	Swelling of Ankles	Yes ___	No ___
Heart Murmur	Yes ___	No ___	Thrombophlebitis	Yes ___	No ___
Cardiologist: __________________			Pulmonary Embolism	Yes ___	No ___

___ **GI Tract:**
Gall Bladder Disease: Yes ___ No ___ Year Removed: _____ Attacks: _____
Hiatal Hernia: Yes ___ No ___ Nissen Procedure: Yes ___ No ___ Year _____
Reflux Disease: Yes ___ No ___ Heartburn: ___ How Often ___ Aspiration____
Colitis/Enteritis: Yes ___ No ___
Liver Disease: Yes ___ No ___
Rectal Bleeding: Yes ___ No ___
Ulcers/Gastritis: Yes ___ No ___

___ **Genito-Urinary:**
Stress Incontinence: Yes ___ No ___ How Often __________ Wear Pad _____
History Kidney/Bladder Infection: Yes ___ No ___
Vaginal Infections: Yes ___ No ___
Blood in Urine: Yes ___ No ___
Prostate Infections: Yes ___ No ___

___ **OB/GYN:**
Last Menstrual Period: _____ Current Contraceptive Method: ________________
Is it possible you are currently pregnant? Yes ___ No ___

PHYSICAL LIMITATIONS:

Climb Stairs Easily: Yes ___ No ___ Able to Use Public Seating: Yes __ No __
Tie Shoelaces Easily: Yes ___ No ___ Pick Up Objects from Floor: Yes __No __
Care for Personal Needs: Yes ___ No ___ Unusual Fatigue: Yes ___ No ___

DRUG ALLERGIES:

___ No Allergies

Drug: ______________________________ Reaction: ______________________
______________________________ ______________________
______________________________ ______________________
______________________________ ______________________
______________________________ ______________________

PRESENT MEDICATIONS:

___ No Medications

Drug: ________________ Dosage: ____________________________________
________________ ____________________________________
________________ ____________________________________
________________ ____________________________________
________________ ____________________________________
________________ ____________________________________

Aspirin Yes ___ No ___ NSAIDS Yes ___ No ___ Coumadin Yes ___ No ___

OPERATIONS:

____________________ Year ________________
____________________ ________________
____________________ ________________
____________________ ________________
____________________ ________________

HX OF SURGICAL COMPLICATIONS:

Bleeding: Yes ___ No ___ Anesthesia Problems: Yes ___ No ___
Transfusion Problems: Yes ___ No ___ Infections: Yes ___ No ___

FAMILY HISTORY: (Any Blood Relatives Had)

Cancer: Yes ___ No ___ Describe: ____
Diabetes: Yes ___ No ___
Heart Attack Before Age 40: Yes ___ No ___
Stroke: Yes ___ No ___
Morbid Obesity: Yes ___ No ___

SOCIAL HISTORY:

Marital Status: S ___ M ___ D ___ W ___ Religious Preference: _________________
Level of Education: _______ Persons Living in the Home: ______
Feeling of Spouse About Surgery: ____
Alcoholic Beverages: None ___ Light ___ Moderate ___ Heavy ___
Smoking History: Never ___ Packs Per Day ___ Year Quit ___
Use Drugs: Yes ___ No ___ Describe ______________________________________
Drink Coffee/Caffeine: Yes ___ No ___

REVIEW OF SYSTEMS:

Pregnancies: Number of Pregnancies ___ Number of Live Births: ___

General: Fevers Yes ___ No ___ Sweats Yes ___ No ___
Fatigue Yes ___ No ___ Other Yes ___ No ___

Dermatological: Rash Yes ___ No ___ Skin Cancer Yes ___ No ___

Special Senses: Visual Problems Yes ___ No ___ Hearing Problems Yes ___ No ___
Ear Ringing Yes ___ No ___ Dizziness Yes ___ No ___

Neurologic: Headaches Yes ___ No ___ Migraines Yes ___ No ___
Seizures Yes ___ No ___ Strokes Yes ___ No ___
Memory Loss Yes ___ No ___ Shaking Yes ___ No ___
Numbness Yes ___ No ___ Incoordination Yes ___ No ___

Infections: Aids Contact Yes ___ No ___ TB Exposure Yes ___ No ___
Immuno Compromised (HIV< Asplenia, Other) Yes ___ No ___
Swollen Glands Yes ___ No ___ Recurring Infections Yes ___ No ___

WEIGHT LOSS ATTEMPTS

Please be as detailed as possible. This information is used in the letter of medical necessity for your insurance carrier.

PROGRAM	YEAR	NO OF MONTHS ON PROGRAM	WT LOSS
Weight Watchers	____	____________	______
	____	____________	______
	____	____________	______
Jenny Craig	____	____________	______
Lendora	____	____________	______
Overeaters Anonymous	____	____________	______
Diet Centers	____	____________	______
Exercise	____	____________	______
Behavior Modification	____	____________	______
Fen-Phen	____	____________	______
Redux/Other (circle one)	____	____________	______
Injections (describe)	____	____________	______
Hypnosis	____	____________	______
Acupuncture	____	____________	______
Jaws Wired	____	____________	______
Medi-Fast/Opti-Fast/HMR (circle one)	____	____________	______
Nutri-System	____	____________	______
Nutritionist	____	____________	______
Psychiatrist/Therapy	____	____________	______
Previous Wt Loss Surgery	____	____________	______
Slim Fast/Sego	____	____________	______
Physician Directed Diet Plan:			
	____	____________	______
	____	____________	______
Self Monitored Diets:			
	____	____________	______
	____	____________	______
	____	____________	______

1st Pregnancy	2nd Pregnancy	3rd Pregnancy
Age ___ Wt Gain ____	Age ___ Wt Gain ___	Age ___ Wt Gain ___

FAMILY HISTORY

Deceased

	Age	Ht	Wt	Medical Condition
___ Mother	___	___	___	___
___ Father	___	___	___	___
___ Siblings	___	___	___	___
	___	___	___	___
	___	___	___	___
	___	___	___	___
___ Spouse	___	___	___	___
___ Children	___	___	___	___
	___	___	___	___
	___	___	___	___
	___	___	___	___
___ Maternal GM	___	___	___	___
___ Maternal GF	___	___	___	___
___ Paternal GM	___	___	___	___
___ Paternal GF	___	___	___	___
___ Maternal Aunt	___	___	___	___
	___	___	___	___
___ Maternal Uncle	___	___	___	___
	___	___	___	___
___ Paternal Aunt	___	___	___	___
	___	___	___	___
___ Paternal Uncle	___	___	___	___
	___	___	___	___

NUTRITIONAL HISTORY

Number of meals per day: ____ Eat between meals: Yes ___ No ___
Do you drink sodas (if yes, how many/day): ___ Diet ___ Regular
How many glasses of water per day: ______

Food Preferences:

Candy ___	Fried Food ___
Chocolate ___	Fast Food ___
Cakes/Pies ___	Steak/Red Meat ___
Cookies ___	Pizza ___
Chips/Snacks ___	Seafood ___
Vegetables ___	Dairy Products ___

YOUR FOOD PATTERN

Instructions: Record the food and amount you've eaten over the last two days.

	Food and Amount
Milk & Milk Products	______________________________
	______________________________
	______________________________
	______________________________
Meat & Meat Alternatives	______________________________
	______________________________
	______________________________
	______________________________
Vegetables & Fruits	______________________________
	______________________________
	______________________________
	______________________________
Breads & Cereals	______________________________
	______________________________
	______________________________
	______________________________
Extra Foods	______________________________
	______________________________
Fast Foods	______________________________
	______________________________
Snacks	______________________________
	______________________________

ASBS BARIATRIC SURGERY CENTERS OF EXCELLENCE

BARIATRIC OUTCOMES LONGITUDINAL DATABASE ("BOLD") INFORMED CONSENT DOCUMENT

This is NOT the consent for your surgery

Title of Research Study:	Bariatric Outcomes Longitudinal Database (BOLD)
Surgeon:	
Hospital:	
Principal Investigator:	Walter J. Pories, M.D.
Research Institution:	Brody School of Medicine East Carolina University 600 Moye Boulevard Greenville, NC 27834
Telephone Number:	(252) 744-3290
Data Coordinating Center:	Surgical Review Corporation 4800 Falls of Neuse Road, Suite 160 Raleigh, NC 27609

INTRODUCTION

You have been asked to take part in a research study being conducted by East Carolina University and Surgical Review Corporation. The study is about bariatric (weight-loss) surgery. Before agreeing to take part in the study, it is important that you read and understand the following information regarding the study. Taking part in the research study is voluntary. If you decide not to take part in the study you will not be penalized or lose any benefits. You can still have weight-loss surgery. You may stop taking part in the study at any time without penalty.

This consent form may contain words that you do not understand. You should ask your surgeon or coordinator to explain any words or information in this consent form that you do not understand.

PURPOSE OF THE STUDY

The weight-loss surgery itself is not part of the study. It will be performed in the same way whether or not you agree to take part in the study.

UMCIRB APPROVED FROM 8·29·07 TO 4·22·08

____
Participant Initials

The purpose of this study is to record and compare the long term results and effects of several types of weight-loss surgery. By comparing the type of surgery performed and the health of patients for five years after their surgery, we hope to learn:

- what types of patients do best after surgery
- the types of surgery that are most helpful, and
- which types of surgeries remain most helpful after five years.

Because you intend to have weight-loss surgery, we would like your surgeon to send us information about your medical condition and your surgery and to send us information about your health and weight loss each year for five years following your surgery.

PARTICIPANTS IN THE STUDY

- All patients who are having weight-loss surgery performed at an American Society for Bariatric Surgery (ASBS) Bariatric Surgery Center of Excellence, including centers which have received Provisional Status designation, will be asked to take part in the study.

- All patients having surgery performed by a surgeon who is a Fellow of the ASBS will be asked to take part in this study whether or not the surgery is performed at an ASBS Bariatric Surgery Center of Excellence.

PERSONS CONDUCTING THE STUDY

Your weight-loss surgeon will send personal health information about you to Surgical Review Corporation, which works with East Carolina University to conduct the research.

PLAN AND PROCEDURES

If you choose to take part in this study, your surgeon will send health information about you to Surgical Review Corporation. Information sent will include:

- your name
- your date of birth
- your height
- your weight
- any prior surgeries
- the date of hospital admission and date of discharge for your weight-loss surgery
- the type of weight-loss surgery performed
- your medical condition before, during and immediately after the surgery
- your health condition and weight following your surgery each year for five years following your weight-loss surgery.

In the future, the researchers may ask you to take part in other research studies about weight and weight-loss surgery. You do not have to take part in these studies unless you want to. You can take part in future studies at the same time that you are taking part in this study.

UMCIRB APPROVED FROM 8·29·07 TO 4·22·08

Participant Initials

If you decide not to have weight-loss surgery, or if the surgery does not occur for other reasons, you will no longer be part of this research study.

If you decide not to take part in the study, we will collect your age, gender, race, ethnicity, height and weight in a manner that cannot be traced back to you in order to have a record of the general medical condition of the people who have been asked but decided not to take part.

POTENTIAL RISKS AND DISCOMFORTS OF PARTICIPATING

There are no risks of physical harm associated with participating in the BOLD research study. The study does involve possible inconvenience in reporting your medical condition. There is a small risk of emotional distress in the event your medical information is inadvertently disclosed to unauthorized third parties.

POTENTIAL BENEFITS OF PARTICIPATING

Participation in the BOLD research study is not expected to provide any direct benefits to you. We hope the information and knowledge gained from the study will help surgeons improve the way the surgery is done and better understand the risks and benefits of each type of weight-loss surgery.

PRIVACY AND CONFIDENTIALITY OF RECORDS

As part of this study, identifiable health information or protected health information ("PHI") about you will be collected and used. The PHI will include demographic information (including your name, date of birth, gender, ethnicity and race), your medical history including prior surgeries and medical conditions, information regarding your weight loss surgery, and information regarding you medical condition following your surgery. Although your name will be collected, it will not be disclosed to the researchers and will only be accessed when necessary in order to identify you if you change surgeons or doctors.

By signing this consent form, you are authorizing the Principal Investigator and his employees and agents, employees and researchers at Surgical Review Corporation, and researchers at East Carolina University working with Surgical Review Corporation on this study to use your PHI in connection with this research study and to further disclose your PHI to representatives of the Institutional Review Board of East Carolina University, representatives of the Institutional Review Board or Research Compliance Office affiliated with your surgeon or hospital, agents of the U.S. Food and Drug Administration or other U. S. Government agencies, and other authorized persons.

If results from this research study are published, you will not be identified by name.

COSTS OF THE WEIGHT-LOSS SURGERY

You or your insurance company will be billed for all costs of the weight-loss surgery. We assume no obligation to pay any money or provide free medical care for your surgery or for any complications which may result from your surgery.

UMCIRB APPROVED FROM 8·27·07 TO 4·22·08

Participant Initials

COSTS OF PARTICIPATION IN THE RESEARCH STUDY

There are no costs to you or your insurance provider for participating in the BOLD research study. No medical or surgical procedures or tests are performed as part of the study.

COMPENSATION FOR PARTICIPATING IN THE RESEARCH STUDY

You will not be paid for participating in the BOLD research study. We assume no obligation to pay any money or provide free medical care in case this research study results in any harm to you.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. You do not have to take part in this study in order to have weight-loss surgery. If you decide not to be in this study or decide to stop participating after it has already started, you may stop at any time without penalty. Your decision not to take part will not affect your medical care in any way.

You have the right to change your mind about permitting us access to your personal health information. If you decide to take away this permission you must notify your surgeon in writing. Any information collected up to the time you take away your permission may still be used. Deciding to no longer allow your information to be used in the study will not result in any penalty or loss to you.

WITHDRAWING YOUR PERMISSION

You may choose to withdraw this Consent as provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at any time after you have signed it by providing your surgeon with a written statement that you wish to withdraw this Consent. Your withdrawal of this Consent will be effective immediately and your protected health information can no longer be used or disclosed for research purposes, except to the extent your surgeon or we have already taken action in reliance on your consent. In addition, your protected health information received before you withdrew consent may continue to be used or disclosed in order to preserve the integrity of an ongoing study.

[continued]

UMCIRB APPROVED FROM 8·29·07 TO 4·22·08

Participant Initials

PERSONS TO CONTACT WITH QUESTIONS

The local investigator (your surgeon or designee) will be available to answer any questions concerning this research, now or in the future. You may contact your surgeon, ____________________, at phone numbers ____________________ (days) or ____________________ (nights and weekends). If you have additional questions, you may contact the Principal Investigator, Surgical Review Corporation, toll free at 866-746-0646. If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days) and/or the ECU Brody School of Medicine Risk Management Office at 252-744-2380 (days)

CONSENT TO PARTICIPATE

Title of research study: Bariatric Outcomes Longitudinal Database (BOLD)

I have read all of the above information. This study has been explained to me. I volunteer to take part in this research study. I have had a chance to ask questions, and I have received satisfactory answers to questions regarding areas I did not understand. I give permission to use my medical information as described in this consent form. (A copy of this signed and dated consent form will be given to the person signing this form as the participant or as the participant's authorized representative.)

____

Participant's Name **(PRINT)** **Signature** **Date**

If applicable:

____

Guardian's Name **(PRINT)** **Signature** **Date**

PERSON ADMINISTERING CONSENT: I have conducted the consent process and orally reviewed the contents of the consent document. I believe the participant understands the research.

____

Person Obtaining consent **(PRINT Name)** **Signature** **Date**

UMCIRB APPROVED FROM 8·29·07 TO 4·22·08

____

Participant Initials