

Bariatric Surgery and Insurance

Dear Patient,

Welcome to our Weight Management Program! Prior to your first appointment with any provider, please contact your insurance company to verify some information. There is a “Members Services” phone number on the back of your insurance card. Firstly, please ask them if they are in network with us. Holyoke Medical Center’s National Provider Identifier (NPI) is 1750395737. Secondly, please ask them if bariatric surgery is a covered benefit. They may ask for a CPT (Current Procedural Terminology) code and the CPT code for the laparoscopic sleeve gastrectomy is 43775. This is the most common procedure that we perform.

It is important that we make sure that your insurance will be covering your visits and the surgery prior to starting the program. If you have any questions, please contact the office at 413-535-4757.

Best regards,

Weight Management Staff

Participating in our program requires a financial commitment. Consider it as an investment in long term health. Some of the costs you can expect will be:

Scale: You must monitor your weight. If you cannot purchase a scale, you can set up weight checks in the office, you must attend all of your appointments. You may choose from the following scale options:

1. Bluetooth Renpho Scale \$28 on Amazon
2. Pohl Scmitt bathroom scale \$22
3. Benign Smart wireless digital scale \$40 on Amazon

Gym membership: This is recommended, but not necessarily required. Gym memberships can start at \$10 per month for some facilities. Sometimes insurance companies offer reimbursement for fitness memberships, so contact your employer about your insurance benefits. If you have a treadmill, stationary bike or elliptical you don't need a gym membership.

If you can buy a treadmill, bike or elliptical it is a better plan than a Gym membership. This way you can use it at your convenience, you save time going from and to the gym, you reduce the risk of getting Covid, you can use it in hours where you would not go to the gym and you save money in the long run because you own it. Whatever aerobic machine you purchase, make sure it tracks calories. A stationary bike is the least expensive, takes the least amount of space and it is a great option for patients with arthritis. Less expensive used equipment options are available on eBay or Facebook.

Meal plan: You will be prescribed a meal plan with protein bars and/or protein shakes. This is to prepare you for surgery and it is essential. You will be using protein shakes after surgery while your stomach heals.

If this is a financial concern, we recommend waiting until you are in a stable financial situation before pursuing surgery. You do not want to put yourself in a position where you cannot afford proper nutrition.

Vitamin Supplementation: You will be on vitamins for life **after** you have surgery. You can expect to spend \$12-\$15 per month on vitamin supplements. Unfortunately, they are not covered by health insurance so you need to be able to buy them yourself.

Name: _____

DOB: _____

Please list any medical conditions you have ever been diagnosed with:

Please list ALL surgical procedures that you have had, including colonoscopy, EGD, oral surgery, etc.:

Please list ALL of your current medications (prescribed and over the counter, including supplements, vitamins, herbal, and birth control). Please include dosage and frequency you take them (i.e., daily, twice a day, every 8 hours, etc.):

(Attach a list if needed)

Please list ALL of your allergies and reactions along with medication intolerances:

Do you drink alcohol? Current Never Former
 Comments:

Do you smoke tobacco? Never used Tobacco Former Tobacco user
 Current everyday Tobacco User Current someday Tobacco user Refuse Tobacco use screen
 Tobacco use Unknown

Type of tobacco use: All Cigarette Pipe Smokeless Tobacco

Cigarette Packs Per day _____

Cigarettes Per Day: _____

Years Smoked:

E-cigarette Tobacco use: Never used Former use Currently using

Do your family members (i.e. parents, children, aunts, uncles have any health conditions? If so, please list all conditions.

- Mother _____
- Father _____
- _____
- _____
- _____
- _____
- _____
- _____

Adverse Childhood Experience (ACE) Questionnaire

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

<p>1. Did a parent or other adult in the household often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?</p>	If yes, enter 1 _____
<p>2. Did a parent or other adult in the household often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?</p>	If yes, enter 1 _____
<p>3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?</p>	If yes, enter 1 _____
<p>4. Did you often feel that... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?</p>	If yes, enter 1 _____
<p>5. Did you often feel that... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?</p>	If yes, enter 1 _____
<p>6. Were your parents ever separated or divorced?</p>	If yes, enter 1 _____
<p>7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?</p>	If yes, enter 1 _____
<p>8. Did you live with anyone who was a problem drinker or alcoholic or who used drugs?</p>	If yes, enter 1 _____
<p>9. Was a household member depressed or mentally ill or did a household member attempt suicide?</p>	If yes, enter 1 _____
<p>10. Did a household member go to prison?</p>	If yes, enter 1 _____

Now, add up your "Yes" answers: _____ This is your ACE Score

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze

1 = **slight** chance of dozing

2 = **moderate** chance of dozing

3 = **high** chance of dozing

Situation

Chance of dozing 0 – 3

- | | |
|--|---------------------|
| 1. Sitting and reading | _____ |
| 2. Watching TV | _____ |
| 3. Sitting inactive in a theater, movie, etc. | _____ |
| 4. As a passenger in a car for an hour without break | _____ |
| 5. Lying down in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly after lunch without alcohol | _____ |
| 8. In a car, while stopped for a few minutes in traffic | _____ |
| | TOTAL: _____ |

ESS < 10: normal, ESS > 12: pathologic

Gastroesophageal Reflux Disease (GERD)

Have you been diagnosed with reflux (GERD)? YES NO

What medications do you take for reflux? _____

Questions about symptoms (circle one for each question)	Scale					
How bad is the heartburn?	0	1	2	3	4	5
Heartburn when lying down?	0	1	2	3	4	5
Heartburn when standing up?	0	1	2	3	4	5
Heartburn after meals?	0	1	2	3	4	5
Does heartburn change your diet?	0	1	2	3	4	5
Does heartburn wake you up from sleep?	0	1	2	3	4	5
Do you have difficulty swallowing?	0	1	2	3	4	5
Do you have pain with swallowing?	0	1	2	3	4	5
If you take medicine for your reflux, does this affect your daily life?	0	1	2	3	4	5
Satisfaction with present condition	Satisfied			Not satisfied		
Total score:						

0 = no symptoms

1 = symptoms noticeable, but not bothersome (slight/occasional),

2 = symptoms noticeable and bothersome, but not daily,

3 = symptoms bothersome every day,

4 = symptoms affect daily activities,

5 = symptoms are incapacitating – unable to do daily activities.

Impact of Weight on Quality of Life Questionnaire—Lite Version (IWQOL-Lite)

Please answer the following statements by circling the number that best applies to you *in the past week*.
Be as open as possible. There are no right or wrong answers.

Physical Function		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I have trouble picking up objects.	5	4	3	2	1
2.	Because of my weight, I have trouble tying my shoes.	5	4	3	2	1
3.	Because of my weight, I have difficulty getting up from chairs.	5	4	3	2	1
4.	Because of my weight, I have trouble using stairs.	5	4	3	2	1
5.	Because of my weight, I have difficulty putting on or taking off my clothing.	5	4	3	2	1
6.	Because of my weight, I have trouble with mobility.	5	4	3	2	1
7.	Because of my weight, I have trouble crossing my legs.	5	4	3	2	1
8.	I feel short of breath with only mild exertion.	5	4	3	2	1
9.	I am troubled by painful or stiff joints.	5	4	3	2	1
10.	My ankles and lower legs are swollen at the end of the day.	5	4	3	2	1
11.	I am worried about my health.	5	4	3	2	1
Total:						

Self-esteem		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I am self-conscious.	5	4	3	2	1
2.	Because of my weight, my self-esteem is not what it could be.	5	4	3	2	1
3.	Because of my weight, I feel unsure of myself.	5	4	3	2	1
4.	Because of my weight, I do not like myself.	5	4	3	2	1
5.	Because of my weight, I am afraid of being rejected.	5	4	3	2	1
6.	Because of my weight, I avoid looking in mirrors or seeing myself in photographs.	5	4	3	2	1
7.	Because of my weight, I am embarrassed to be seen in public places.	5	4	3	2	1
Total:						

Sexual Life		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I do not enjoy sexual activity.	5	4	3	2	1
2.	Because of my weight, I have little or no sexual desire.	5	4	3	2	1
3.	Because of my weight, I have difficulty with sexual performance.	5	4	3	2	1
4.	Because of my weight, I avoid sexual encounters whenever possible.	5	4	3	2	1
Total:						

Public Distress		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I experience ridicule, teasing, or unwanted attention.	5	4	3	2	1
2.	Because of my weight, I worry about fitting into seats in public places (e.g. theaters, restaurants, cars, or airplanes).	5	4	3	2	1
3.	Because of my weight, I worry about fitting through aisles or turnstiles.	5	4	3	2	1
4.	Because of my weight, I worry about finding chairs that are strong enough to hold my weight.	5	4	3	2	1
5.	Because of my weight, I experience discrimination by others.	5	4	3	2	1
Total:						

Work (Note: For homemakers and retirees, answer with respect to your daily activities.)		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I have trouble getting things accomplished or meeting my responsibilities.	5	4	3	2	1
2.	Because of my weight, I am less productive than I could be.	5	4	3	2	1
3.	Because of my weight, I don't receive appropriate raises, promotions or recognition at work.	5	4	3	2	1
4.	Because of my weight, I am afraid to go on job interviews.	5	4	3	2	1
Total:						

Grand Total _____

Weight Management Program (WMP) Cancellation and No show Policy

In order to keep our program running efficiently and to make sure that patients have their follow up appointments in a timely manner we have developed a cancellation and no show policy. We understand that there may be times that you will need to cancel and reschedule an appointment, please follow the instructions below to make sure that this will not jeopardize your participation in our program.

You will receive a call from one of our staff before all of your appointments in our office.

PLEASE FOLLOW THE INSTRUCTIONS TO CONFIRM YOUR APPOINTMENT.

If you do not confirm your appointment, this appointment time may be given to another patient from our wait list.

IF YOU NEED TO CANCEL YOUR APPOINTMENT-You must call the office at least 24 hours before your appointment time to inform us. If we do not hear from you, or if you are more than 15 minutes late you will be considered a “no show”.

If you have multiple no shows, the bariatric team will determine whether you will have access to subsequent appointments in our department.

My signature below signifies that I have read and understand the WMP’s cancelation and No Show policies and I agree to comply with them.

SIGNATURE: _____

DATE: _____

Behavioral Health Services in the Weight Management Program

I understand that as part of my initial and ongoing weight management treatment I will be evaluated by a Behavioral Health provider who will assess my initial and ongoing psychological readiness and perioperative progress and psychological and behavioral needs. I understand that the records of my Behavioral Health sessions, maintained in a confidential manner, will be available to the Weight Management team and will consent to disclosure of same. I understand that I may need to participate in more intensive psychological counseling and therapy to maximize my overall wellness and weight loss goals and that my consent will be required to disclose the content of those conversations.

By voluntarily signing this document, I confirm that I have read and agree with the above program requirement.

Name _____ Date _____

EFFORTS AT WEIGHTLOSS

NAME: _____ DATE: _____

What type(s) of diet(s), if any, have you followed in the past?

Please give approximate dates and be very thorough.

Diet/Methods	Start Date	End Date	Weight Lost	Wgt Regained
Diminishing Dimensions				
Jenny Craig				
NutriSystems				
TOPS (Take Off Pounds Sensibly)				
Weight Watchers				
Overeaters Anonymous				
Liquid / Protein Diet <i>Specify:</i>				
Other commercial weight loss program(s):				
Over the Counter Diet Pills				
Prescription Diet Pills <i>Specify:</i>				
Medically Supervised				
Registered Dietician				
Alternative Medicine: (acupuncture, hypnosis, naturopathic doctor) <i>Specify:</i>				
Surgical Intervention: (gastric bypass, liposuction, wired jaw) <i>Specify:</i>				
Fad Diets: (Atkins, Blood Type Diet, Cabbage Soup, Grapefruit Diet, South Beach, Sugar Busters, The Zone, Keto, etc.) <i>Specify:</i>				
Others: <i>(Please specify)</i>				

Weight Trend in the Past 5 Years

Current Year: _____ Weight: _____
 Year: _____ Weight: _____
 Year: _____ Weight: _____
 Year: _____ Weight: _____
 Year: _____ Weight: _____

Please Circle All Positive Responses

Excessive tiredness

Acid reflux

Fever

Blood in stool

Headache

Constipation

Lightheadedness

Diarrhea

Interrupted sleep

Exposure to hepatitis

Difficulty falling asleep

Nausea

Snoring

Vomiting

Stop breathing during sleep

Easy bruising

Difficulty swallowing

Prolong bleeding

Irregular menses

Loss of urine with coughing or laughing

Excessive thirst

Kidney stones

Cough

Back pain

Shortness of breath

Knee pain

Shortness of breath with simple tasks

Shoulder pain

Wheezing

Skin rashes

Chest pain

Loss of strength

Irregular heart beat

Anxiety

Leg swelling

Depression

Stomach ulcer

Thoughts of hurting yourself

Explanation of Bariatric Registry Consent

This practice is one of the best in the country in terms of outcomes. This is not by accident but because Dr. Raftopoulos puts an enormous effort to collect and analyze the data of all patient's outcomes and constantly improve the practice based on objective information. By providing your consent today, you are contributing to this ongoing process and help future patients to have the best outcomes possible as past patients contributed for you to get the best outcomes possible. Although it is your right not to provide your consent to collect and analyze your data, by not providing your data, you are limiting our ability to make the best possible decisions and interpretations as the data will be skewed by the fact that some patients did not participate. Your data are only accessible by Dr. Raftopoulos, they are de-identified and it is not shared with anyone outside the practice.

Sincerely,

Ioannis Raftopoulos, MD, FACS

CONSENT TO ACT AS A PARTICIPANT IN THE BARIATRIC REGISTRY

TITLE: Bariatric Registry

PROTOCOL NO.: None
WCG IRB Protocol #20250236

SPONSOR: Holyoke Medical Center

INVESTIGATOR: Ioannis Raftopoulos, MD
Holyoke Medical Center
11 Hospital Drive
3rd Floor
Holyoke, Massachusetts 01040
United States

**STUDY-RELATED
PHONE NUMBER(S):** (413) 535-4757

Your participation in this study is voluntary. You may decide not to participate or you may leave the study at any time. Your decision will not result in any penalty or loss of benefits to which you are otherwise entitled.

If you have questions, concerns, or complaints, or think this research has hurt you, talk to the research team at the phone number(s) listed in this document.

RESEARCH CONSENT SUMMARY

You are being asked for your consent to take part in a research study. This document provides a concise summary of this research. It describes the key information that we believe most people need to decide whether to take part in this research. Later sections of this document will provide all relevant details.

How long will I be in this research?

We expect that your taking part in this research will last as long as the Bariatric Registry is active.

Why is this research being done?

The purpose of this research is to collect your medical record information to be placed anonymously (without your name and any personal information) into the Bariatric Registry. First, it will allow us to review and study the medical records of many individuals to answer questions about your disease and its treatment, and second, it will help our Weight Management program to identify and recruit patients who are eligible for participation in future studies unrelated to this Bariatric Registry.

What happens to me if I agree to take part in this research?

If you decide to take part in this research study, your medical record information will be placed anonymously (without your name and any personal information) into the Bariatric Registry.

Could being in this research hurt me?

There are no risks of physical injury associated with your participation in the Bariatric Registry. There is the risk of a loss of confidentiality of your research-related information.

Will being in this research benefit me?

It is not expected that you will personally benefit from this research.

What other choices do I have besides taking part in this research?

This research is not designed to diagnose, treat or prevent any disease. Your alternative is to not take part in the research.

What else should I know about this research?

Identifiers will be removed from your private information and then might be used or distributed for future research studies without your additional informed consent.

DETAILED RESEARCH INFORMATION

What is the purpose of this Research Registry?

Many advancements in medicine have resulted from research involving the collection and analysis of the medical record information of patients with a certain disease or condition. If you are a patient of the Weight Management program at Holyoke

Medical Center, or of the Endocrine department at Holyoke Medical Center, or you wish to use the RightBMI software application (RightBMI app), we are asking for your permission to allow us to place your medical record information into a Bariatric Registry (Database). The data will be de-identified which means they will not contain any personal information that could be linked back to you. If you are a patient of the Weight Management program only your physician Dr. Raftopoulos and his assistants Mr. Bell and Ms. Kuselias will have access to your personal information in order to be able to provide you the care you need. If you are a patient of the Endocrine department only your physician will have access to your personal information in order to be able to provide you the care you need. If you use the RightBMI app, no personal information are stored by the RightBMI app. By placing the medical record information of many patients such as you into a registry, we will be able to conduct studies directed at increasing our knowledge about Weight Loss with or without the use of the RightBMI app.

It is anticipated that the Bariatric Registry will assist in two important ways.

First, it will allow us to review and study the medical records of many individuals to answer questions about your disease and its treatment.

Second, it will help our Weight Management program to identify and recruit patients who are eligible for participation in future studies unrelated to this Bariatric Registry. For example, our physicians associated with the Weight Management program at Holyoke Medical Center are also frequently involved in studies directed at evaluating the safety and effectiveness of drugs, devices or procedures related to Weight Loss. If you agree to participate in this Bariatric Registry, your medical record information will be reviewed by our physicians only to determine if you might qualify for various future research studies. Participation in these future studies will not be automatic, but it will occur only if you agree to participate. **Only if you are a patient of the Weight Management program you may be asked to participate in future studies.**

Who is being asked to participate in this Bariatric Registry?

All adult patients (age greater than or equal to 18 years old) who are seeking treatment or are being treated at the Weight Management program at Holyoke Medical Center, or at the Endocrine department at Holyoke Medical Center or they agree to use the RightBMI app are being asked to participate in this Bariatric Registry.

What will my participation in this Bariatric Registry involve?

If you agree to participate in the Bariatric Registry, your medical record information will be placed **anonymously (without your name and any personal information)** into the Bariatric Registry. This will permit studies to be conducted on the medical record information contained within the registry. **Only if you are a patient of the Weight Management program at Holyoke Medical Center,** you are being asked to allow us to contact you if one of our bariatric surgeons determines, through review of your medical record information contained in the Bariatric Registry that you are eligible for participation in a future study directed at the study of Weight Loss. Please note that if you qualify for any future research studies, which are unrelated to the information placed in this Bariatric Registry, you will be asked to provide a separate approval and sign a separate consent form that outlines in detail the nature of this research study, including its potential risks and benefits.

If you are a patient of the Weight Management program or the Endocrine department at Holyoke Medical Center you may be asked to use the RightBMI software application as part of your treatment to lose weight and improve your diabetes (if you have diabetes). Use of the RightBMI app is entirely your choice. If you are not a patient of the Weight Management program or the Endocrine department at Holyoke Medical Center, you have chosen to use the RightBMI app.

The RightBMI app has been designed by Dr. Raftopoulos and is the only available software tool that can generate automatically structured and individualized meal and exercise plans that are specifically customized to your unique characteristics and preferences.

We ask you to allow us to collect de-identified data from using the RightBMI app to improve it further. Although we cannot guarantee that use of the RightBMI app will benefit you, the RightBMI app has been used already by over 200 patients with excellent results without observing any side effects or complications. Use of the RightBMI app has contributed to maximizing fat loss while preserving muscle mass.

What are the possible risks of my participation in the Bariatric Registry?

There are no risks of physical injury associated with your participation in the Bariatric Registry. Participation in this Bariatric Registry does involve the possible risk that information about your health might become known to individuals outside of the Weight Management program at Holyoke Medical Center.

Revised 2-2-2025

Participant's Initials _____

We will attempt to preserve your medical record confidentiality by assigning a special research code number to your medical record information stored in the Bariatric Registry, and by removing personal identifiers (for example, your name, social security number, medical record number) from information stored about you in the Bariatric Registry. The Bariatric Registry will be secured in the Hospital's secure drives. Information linking the research code number to your name and other personal identifiers will be stored in a separate secure location. Access to any identifiable information about you that is contained within the Bariatric Registry will be limited to the investigators associated with our Weight Management program Registry.

What are the possible benefits of my participation in the Bariatric Registry?

Medical record information contained within the Bariatric Registry will be used for studies directed at improving our knowledge and outcomes and this knowledge may benefit you as well as patients for Weight Loss in the future.

Will I or my insurance provider be charged for my participation in the Bariatric Registry?

There will be no costs to you or your insurance provider to participate in this Bariatric Registry.

Will I be paid for my participation in the Bariatric Registry?

No, you will not receive any payment for participating in this Bariatric Registry.

Who will know about my participation in this Bariatric Registry?

Any information from your medical records that is placed in this Bariatric Registry will be kept as confidential (private) as possible. In addition, you will not be identified by name in any publication of the results of research studies involving the use of your medical record information unless you sign a separate consent form (release) giving your permission.

Some of your data will be shared with the American Society of Metabolic and Bariatric Surgery as part of our mandatory Center of Excellence outcome reporting requirements. All data will be de-identified prior to submission.

What is the nature of my medical record information that will be placed into the Bariatric Registry?

All of your past, current and future medical record information related to your Weight Loss will be recorded into the Bariatric Registry. Since medical conditions and treatments not related directly to your Weight Loss may affect Weight Loss and/or its treatment, it is likely that all of your existing and future medical record information will be placed in the Bariatric Registry. This information will be collected from your Weight Management records, hospital records and, if applicable, private physician records.

Who will have access to my identifiable medical record information contained in the Bariatric Registry?

Access to your identifiable medical record information contained within this Bariatric Registry will be limited to Weight Management investigators. A current, complete listing of these individuals will be provided to you upon your written request.

In addition, the Weight Management investigators may have access to your identifiable medical record information contained within this Bariatric Registry.

Authorized representatives of Holyoke Medical Center Institutional Review Board and WCG IRB may review information contained within the Bariatric Registry to ensure that the Bariatric Registry adequately protects your privacy.

In unusual cases, the researchers may be required to release your identifiable medical record information from the Bariatric Registry in response to an order from a court of law.

For how long will my medical record information continue to be placed in the Bariatric Registry and for how long will this information be used for research purposes?

We will continue to place your medical record information into the Bariatric Registry until you withdraw your permission for participation in the Bariatric Registry.

Your medical record information contained within the Bariatric Registry will be used for research purposes for an indefinite period of time.

Is my participation in the Bariatric Registry voluntary?

Your participation in the Bariatric Registry, to include the use of your medical record information for the research purposes described above, is completely voluntary. Whether or not you provide your permission for participation in this Bariatric Registry will have no affect on your current or future medical care at Holyoke Medical Center, affiliated health care provider, or your current or future relationship with a health care insurance provider. Whether or not you provide your permission for participation in this Bariatric Registry will have no affect on your current or future relationship with Holyoke Medical Center.

This research is not designed to diagnose, treat or prevent any disease. Your alternative is to not take part in the research.

May I withdraw, at a future date, my consent for participation in this Bariatric Registry?

You may withdraw, at any time, your consent for participation in the Bariatric Registry, to include the additional collection of your medical record information and its further use for the research purposes described above. However, any research use of your medical record information prior to the date that you formally withdraw your permission will not be destroyed.

To formally withdraw your permission for participation in the Bariatric Registry you should provide a written and dated notice of this decision to the principal investigator of the Bariatric Registry at the address listed on the first page of this consent form.

VOLUNTARY CONSENT

I understand all the information provided and I don't have any questions. I understand that I am encouraged to ask questions about any aspect of my participation in the Bariatric Registry at any time, and that such future questions will be answered by the physicians associated with the Weight Management program or their staff. I understand that a copy of this consent form will be given to me.

I understand that any questions about this research study will be answered by the Investigator or Co-Investigators (11 Hospital Drive, 3rd floor, Holyoke, MA 01040, tel: 413-535-4757, email: Raftopoulos_ioannis@holyokehealth.com).

This research is being overseen by WCG IRB. An IRB is a group of people who perform independent review of research studies. You may talk to them at 855-818-2289 or clientcare@wgcclinical.com if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.

By signing below, I agree to participate in the Bariatric Registry.

Printed Name of Participant

Participant's Signature

Date

Institutional Review Board
IRB #:20250236
IRB APPROVED
Feb 02, 2025

CERTIFICATION OF INFORMED CONSENT

I certify that I understand the nature and purpose of the Bariatric Registry to the above-named individual, as well as the possible risks and potential benefits of participation in this Bariatric Registry. Any questions the individual has about this Bariatric Registry have been answered, and the physician and staff associated with the Weight Management program will be available to address future questions as they arise.

Printed Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date



Behavioral Health Assessment Paperwork

As part of our program, you will meet with a licensed mental health clinician for a psychological assessment prior to bariatric surgery. To help us better understand your needs, please complete the following questionnaires and forms:

- Mental Health form and Release of Information *
- PHQ-9
- Binge Eating Scale

** If you are currently receiving any form of mental health treatment, we will require you to complete the Consent to Release and Obtain Information form. This may be necessary to obtain additional documentation before proceeding with your surgery.*

Thank you for your cooperation.



Mental Health Information

NAME: _____ DOB: _____

Please answer the following questions to the best of your ability. Your responses will help us facilitate your initial visit with the Behavioral Health provider and complete the psychological evaluation required by your insurance for bariatric surgery.

1. Do you currently receive services from a Behavioral Health Provider, such as counseling, therapy, or psychiatric medication management?

NO

YES,

Please list the name of your current provider:

Name of provider: _____

Name of the agency: _____

Address: _____

Phone Number: _____

Please complete the Release of Information form for this provider, as we may need to request additional information.

2. Are you currently being treated for any mental health condition by your Primary Care Provider (PCP)?

NO

YES. Please provide your diagnosis and/or medications: _____

3. Please select any services you have attended in the last 2 years:

Individual Counseling

Outpatient Psychiatric Visits

TMS (Transcranial Magnetic Stimulation)

IOP (Intensive Outpatient Program)

PHP (Partial Hospitalization Program)

Detox Program

Inpatient Mental Health Hospitalization

PATIENT NAME: _____ DATE OF BIRTH: _____
MEDICAL RECORD NUMBER: _____ PHONE #: _____

RELEASE FROM HOLYOKE MEDICAL CENTER (HMC): I authorize HMC to release my health information to:

Name: _____

Address: _____

What to Release: _____ Dates of Service: _____

Please include the following information: Entire Record, **OR** the following (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Abstract (Provider notes, test results) | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Lab results <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Work Connection (OHS / OHC / EHP) |
| <input type="checkbox"/> Radiology Reports (X-Ray, MRI CT) <input type="checkbox"/> Films | <input checked="" type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Cardiology / EKG Reports | <input type="checkbox"/> Inpatient <input type="checkbox"/> PHP / IOP <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Other _____ | |

Purpose of Request: Continuity of Care Legal Personal Other: _____

RELEASE TO HMC: I authorize _____ to release my health information to:
Holyoke Medical Center, Attention Dept. WMP- Bariatric surgery 575 Beech St., Holyoke, MA 01040 FAX: 413-534-2618

What to Release: _____ Dates of Service: ALL

Please include the following information:

- | | |
|--|---|
| <input type="checkbox"/> Abstract (Provider notes, test results) | <input checked="" type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Discharge/Transfer Summary | <input checked="" type="checkbox"/> Psychosocial Assessment <input checked="" type="checkbox"/> Medication Management Information |
| <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Films | <input checked="" type="checkbox"/> Treatment Plan/Progress <input checked="" type="checkbox"/> Presence/Progress/Participation Treatment |
| <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory & Pathology Reports | <input type="checkbox"/> Admission & Discharge note for hospitalization (dates) _____ |
| <input checked="" type="checkbox"/> Other <u>Provider to complete MH form sent</u> | |
| <input type="checkbox"/> Other _____ | |

Purpose of Request: Continuity of Care Legal Personal Other: Bariatric surgery

RELEASE OF PRIVILEGED INFORMATION:

____ (Initials) **HIV/AIDS:** I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment related to Acquired Immune Deficiency Syndrome (AIDS) only to the person or organization named above and only for the purpose name above.

____ (Initials) **GENETIC TESTING:** I hereby authorize release of protected health information pertaining to genetic test results only to the person or organization named above and only for the purpose name above.

____ (Initials) **ALCOHOL and DRUG TREATMENT:** I hereby authorize release of treatment records of a licensed drug and alcohol treatment program to the person or organization named above and only for the purpose name above. I also understand that my Alcohol and Drug Abuse Records cannot be re-disclosed without my express authorization.

X ____ (Initials) **INPATIENT PSYCHIATRIC RECORDS OR RECORDS OF A PSYCHOLOGIST OR PSYCHOTHERAPIST:** I hereby authorize release of psychiatric treatment records, and/or records of a psychologist or psychotherapist only to the person or organization named above and only for the purpose name above.

____ **Domestic violence abuse counselor records** ____ **Social service records** ____ **Sexual assault counselor records**
____ **Sexually transmitted disease records**

INDIVIDUAL RIGHTS: I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Medical Records Dept, HMC, 575 Beech St., Holyoke, MA 01040, or must contact the party whom I had authorized to release the information, if other than HMC.
- My right to revoke does not apply to information already released on the basis of this authorization.
- The privacy of my health records is protected under "HIPAA," 45 CFR, pts 160 & 164, and the privacy of any alcohol and/or drug treatment records are also protected under the Federal Confidentiality & Drug Abuse Records regulations, 42 CFR, pt 2.
- I understand that Holyoke Medical Center cannot guarantee that the Recipient will not re-disclose my health information to anyone else.
- There may be a charge for providing copies of medical records.

Expiration Date: This authorization will expire in one year unless revoked or otherwise specified to be the following date, event or condition:

(person's initials) _____ Conclusion of this Treatment Episode (person's initials) _____ Other: _____

Signature: X _____ Date: X _____

If not signed by person served, specify relationship: Parent Legal Guardian/Designee Holyoke Medical Center

**AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Binge Eating Scale (BES)

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Introduction

The Binge Eating Scale (BES) is a self-report instrument developed to assess the presence and behavioral manifestations of Binge Eating Disorder (BED). Developed by Gormally et al. in 1982, the scale was designed to identify behaviors, emotions, and attitudes related to binge eating episodes among individuals who might be at risk of developing BED. Comprising 16 items, the BES evaluates both the severity and frequency of binge eating episodes, which are central in diagnosing and understanding the disorder.

Each item on the BES presents a set of four statements arranged in a graded severity format, reflecting an increasing level of binge eating symptomatology. Respondents select the statement that best describes their experience, with higher scores indicating more severe binge eating behaviors. This method allows for the quantification of binge eating tendencies without the need for a clinical interview. The total score ranges from 0 to 46, with higher scores correlating with more frequent and severe binge eating behaviors. This scoring system has been validated through various studies, showing good internal consistency and satisfactory test-retest reliability.

The utility of the BES extends beyond the diagnosis of Binge Eating Disorder. It is also used in clinical settings to monitor changes in binge eating behavior over time, making it a valuable tool for assessing treatment outcomes. Furthermore, researchers employ the BES in studies to explore the psychopathological features of binge eating and its association with obesity and other psychological disorders. Despite its widespread use, it is advisable for clinicians and researchers to use the BES alongside other diagnostic tools and interviews to ensure comprehensive assessment and accurate diagnosis. Overall, the Binge Eating Scale remains a respected instrument in both clinical and research contexts, contributing to the broader understanding and treatment of binge eating disorders.

Instructions

Below are groups of statements about behavior, thoughts, and emotional states. Please indicate which statement in each group best describes how you feel.

1.

- I don't feel self-conscious about my weight or body size when I'm with others.
- I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
- I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
- I feel very self-conscious about my weight and frequently, I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.

2.

- I don't have any difficulty eating slowly in the proper manner.
- Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
- At times, I tend to eat quickly and then, I feel uncomfortably full afterwards.
- I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because I've eaten too much.

3.

- I feel capable to control my eating urges when I want to.
- I feel like I have failed to control my eating more than the average person.
- I feel utterly helpless when it comes to feeling in control of my eating urges.
- Because I feel so helpless about controlling my eating I have become very desperate about trying to get in control.

4.

- I don't have the habit of eating when I'm bored.
- I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
- I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.
- I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.

5.

- I'm usually physically hungry when I eat something.
- Occasionally, I eat something on impulse even though I really am not hungry.
- I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need the food.
- Although I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth. Sometimes, when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain weight.

6.

- I don't feel any guilt or self-hate after I overeat.
- After I overeat, occasionally I feel guilt or self-hate.
- Almost all the time I experience strong guilt or self-hate after I overeat.

7.

- I don't lose total control of my eating when dieting even after periods when I overeat.
- Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more.
- Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When that happens I eat even more.
- I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."

8.

- I rarely eat so much food that I feel uncomfortably stuffed afterwards.
- Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed.
- I have regular periods during the month when I eat large amounts of food, either at mealtime or at snacks.
- I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit nauseous.

9.

- My level of calorie intake does not go up very high or go down very low on a regular basis.
- Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate for the excess calories I've eaten.
- I have a regular habit of overeating during the night. It seems that my routine is not to be hungry in the morning but overeat in the evening.
- In my adult years, I have had week-long periods where I practically starve myself. This follows periods when I overeat. It seems I live a life of either "feast or famine."

10.

- I usually am able to stop eating when I want to. I know when "enough is enough."
- Every so often, I experience a compulsion to eat which I can't seem to control.
- Frequently, I experience strong urges to eat which I seem unable to control, but at other times I can control my eating urges.
- I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating voluntarily.

11.

- I don't have any problem stopping eating when I feel full.
- I usually can stop eating when I feel full but occasionally overeat leaving me feeling uncomfortably stuffed.

- I have a problem stopping eating once I start and usually I feel uncomfortably stuffed after I eat a meal.
- Because I have a problem not being able to stop eating when I want, I sometimes have to induce vomiting to relieve my stuffed feeling.

12.

- I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself.
- Sometimes, when I'm with other persons, I don't eat as much as I want to eat because I'm self-conscious about my eating.
- Frequently, I eat only a small amount of food when others are present, because I'm very embarrassed about my eating.
- I feel so ashamed about overeating that I pick times to overeat when I know no one will see me. I feel like a "closet eater."

13.

- I eat three meals a day with only an occasional between meal snack.
- I eat 3 meals a day, but I also normally snack between meals.
- When I am snacking heavily, I get in the habit of skipping regular meals.
- There are regular periods when I seem to be continually eating, with no planned meals.

14.

- I don't think much about trying to control unwanted eating urges.
- At least some of the time, I feel my thoughts are pre-occupied with trying to control my eating urges.
- I feel that frequently I spend much time thinking about how much I ate or about trying not to eat anymore.
- It seems to me that most of my waking hours are pre-occupied by thoughts about eating or not eating. I feel like I'm constantly struggling not to eat.

15.

- I don't think about food a great deal.
- I have strong cravings for food but they last only for brief periods of time.
- I have days when I can't seem to think about anything else but food.
- Most of my days seem to be pre-occupied with thoughts about food. I feel like I live to eat.

16.

- I usually know whether or not I'm physically hungry. I take the right portion of food to satisfy me.
- Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times it's hard to know how much food I should take to satisfy me.
- Even though I might know how many calories I should eat, I don't have any idea what is a "normal" amount of food for me.

Score my Answers

Sources

1. J Gormally, S Black, S Daston, D Rardin. The assessment of binge eating severity among obese persons. 7(1): Addict Behav 47-55 (1982).
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