Blossom Bariatrics
Thomas Umbach, MD

BLOSSOM MEDICAL GROUP

Patient's Name:_____

DOB:_____

Informed Consent for Adjustable Band Consent Form

I hereby authorize **Blossom Bariatrics** to perform an adjustment on my adjustable gastric band. In addition to any other agreements with Blossom Bariatrics, my consent to and understanding of the following terms and information is necessary for the procedure and my care.

I understand that this procedure involves penetrating the skin over the port, blindly using a special needle for the purpose of instilling or withdrawing fluid from the band around the stomach in order to achieve stomach restriction and weight loss.

I certify that I have been informed that there are significant risks including, but not limited to, bleeding, infection (that may necessitate removal of the port or band with attendant risk of recurrence of morbid obesity), catheter, port and/or band damage that may require prolonged antibiotic treatment, anesthetic risks (including shock/death) cardio-respiratory arrest, damage to the port or catheter (resulting in its removal/replacement), band erosion, fistula formation, damage to nerves, blood vessels, skin, intra-abdominal or thoracic structures including the gastrointestinal system, liver, heart, lungs and pleura, intra-abdominal infection, band slippage, pouch dysfunction, dysphasia, esophageal dilatation or dysfunction, heartburn, gastritis, ulceration, gastric outlet obstruction, reflux esophagitis / inflammation / Barrett's esophageal cancer, esophageal motility problems, pain, scar, need for open wounds, inability/difficulty eating certain types of food or pills, or a need for additional surgery or procedures. I fully understand the possibility of esophageal dilation / reflux esophagitis / inflammation / Barrett's / esophageal cancer / motility problems; over-stretching of the pouch; poor emptying from the pouch; erosion / band slippage / stomach herniation can occur with over-tightening of the band. I recognize that the long-term consequences/risks of this device are unknown. I therefore fully understand that unforeseen conditions may require additional procedures / surgery / investigations for which I will assume full responsibility/financial and otherwise. I further understand that this (adjustable gastric band) requires lifelong medical surveillance and modification of food choices. These include, but are not limited to, the amount and frequency, as well as, a life-long need for nutritional supplementation including, but not limited to, proteins, vitamins, minerals and fluids. I also certify that I have been informed about the alternatives (including non-treatment).

I hereby acknowledge that no warranty or guarantee has been given or implied to me with regard to the outcome. I will refrain from having this device adjusted by anyone other than by health-care providers who are qualified by education, training and experience to handle this device.

I have read and fully understand the above consent, and after carefully considering all the possible risks and consequences and alternatives (including non-treatment), I willingly consent to the above-mentioned procedure.

Signature: _____ Date:_____

ADJUSTABLE GASTRIC BAND ADJUSTMENT

After obtaining informed consent, under sterile conditions and local anesthesia (with 1% lidocaine without epinephrine), the port was accessed **without difficulty** / **with difficulty** using a **1½ / 2¾ / 3½ inch 22g / 20g** Huber needle. _____mL was withdrawn **under pressure** / **without pressure** and _____mL of normal saline was instilled bringing the **TOTAL** to _____mL. Its location within the port was confirmed in the usual fashion.

- ❑ Patient tolerated the procedure well; was able to drink a glass of water without difficulty.
- ❑ Patient was unable to drink a glass of water, so _____ mL was removed bringing the **TOTAL** to _____ mL.
- ❑ Patient felt no restriction so an additional _____ mL was instilled bringing the **TOTAL** to _____ mL.
- ❑ Patient advised to limit PO intake to liquids for 48 hours.

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Mutual Binding Arbitration Agreement

Patient's Name: _____

This mutual binding Arbitration Agreement constitutes an integral part of a contract for medical services by and between **Blossom Bariatrics** and Patient who agree to be bound as described hereunder:

1. Any dispute, claim or controversy arising out of or relating to any Consent for Treatment or Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this Arbitration Agreement, shall be determined by arbitration in Clark County, Nevada before one arbitrator with at least 10 years of active litigation experience, unless otherwise directed herein. If the amount claimed is less that $250,000, the arbitration will be administered by JAMS in accordance with JAMS' Streamlined Arbitration Rules and Procedures. For claims in excess of $250,000, the Comprehensive Arbitration Rules and Procedures will apply.

2. This Arbitration Agreement expressly applies to any claims for medical malpractice as defined by Nevada law. Any medical malpractice claims will be arbitrated before a panel of three arbitrators. NRS 41A will apply to any such arbitration proceedings, with the arbitration panel taking the place and stead of the district court. NRS 41A.071 specifically applies to any arbitration proceeding, which requires a malpractice claim to be filed with an affidavit supporting the claims by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice of Blossom Bariatrics. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Within 15 days after the commencement of arbitration, each party shall select one person to act as arbitrator. The parties will communicate their selected arbitrator to the JAMS Case Manager. If a party fails to select an arbitrator within 15 days, JAMS will appoint an arbitrator. The two party-determined arbitrators will select a third arbitrator to serve as panel chair within 30 days of the commencement of the arbitration. The panel must be chaired by an attorney with at least 20 years of active litigation experience or a retired judge from a court having jurisdiction in Nevada. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator within the allotted time, the third arbitrator shall be appointed by JAMS in accordance with its rules and the criteria set forth above. All arbitrators shall serve as neutral, independent, and impartial arbitrators.

3. This Arbitration Agreement applies to any claim against Dr. Thomas W. Umbach individually, Blossom Bariatrics and/or Blossom Medical Group, or any employees or contracted staff of Blossom Bariatrics. This Arbitration Agreement and the rights of the parties in relation to any claims shall be governed by and construed in accordance with the laws of the State of Nevada.

4. Judgment on the arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

5. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Blossom Bariatrics. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.

6. The Arbitration Agreement shall bind the parties hereto, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

Printed Name: _____

Signature: _____ Date: _____

(patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: _____

Assignment of Insurance Payments

Blossom Bariatrics bills your insurance as a courtesy for all in network and out of network policies. Occasionally the insurance company will send payment directly to the patient. If this does happen with your policy, simply sign the check “Pay to the order of Blossom Bariatrics” then you sign underneath. Be sure to send a copy of all correspondence that comes with it as well.

I understand and acknowledge that I have a legal obligation to pay for the services I have received or will receive from Blossom Bariatrics.

I also acknowledge that if my health insurance company covers the medical procedures I have received or will be receiving, that payment from my health insurance company should be paid to Blossom Bariatrics. ***Under no circumstances am I entitled to receive and keep any payments from my health insurance company. These payments are rightfully owed to Blossom Bariatrics in payment for the services I have received from them.***

THEREFORE, I hereby assign to Blossom Bariatrics any and all sums of money which I have received to date or which I may receive in the future from my health insurance company.

I HEREBY authorize and instruct _____

Insurance Company, Policy #_____to pay all sums which it has paid or would pay to me directly to Blossom Bariatrics at the following address:

Blossom Bariatrics
7385 S Pecos Rd
Las Vegas, Nevada 89120

This Assignment is to remain in full force and effect for all claims submitted and all payments made from the date this Assignment is executed below until it is revoked in writing.

Signature: _____Date: _____

Printed Name: _____

Blossom Witness Signature:_____

Blossom Printed Name: _____ Date: _____