Kent C. Sasse, M.D., MPH, FACS, FASCRS, FASMBS

DEMOGRAPHIC SHEET

Patient Legal Name: _____
Last First Middle

Preferred name (if different from first name): _____

Seminar Date: _____/_____/_____

How did you hear about us?

- ❑ Television
- ❑ Radio
- ❑ Print
- ❑ Friends and Family
- ❑ Doctor
- ❑ Other: _____

DOB: _____ Gender: Male___Female___ Social Security #: _____

Mailing Address: _____
Address City State Zip Code

Physical Address (if different from above): _____

Daytime Phone Number: _____ Home Phone: _____

Cell Phone: _____ Email: _____

May we email you correspondence at the email listed above: Yes___ No___

Can we leave detailed messages on your answering machine/voicemail? Yes___No___ N/A___

Preferred Form of Contact (please choose one): Phone___ Email___ Patient Portal____

<u>Required Government Information:</u>

Race (Check the ONE you most identify with):

- ❑ White
- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian/Pacific Islander
- ❑ Other Race/Unknown
- ❑ Declined

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Declined

Religion:

- ❑ Buddhist
- ❑ Catholic
- ❑ Hindu
- ❑ Islam
- ❑ Jewish
- ❑ Protestant/Christian
- ❑ Unknown/NA
- ❑ Declined
- ❑ Jehovah's Witness
  - ○ Bloodless

Marital Status:

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced
- ❑ Other: _____

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Name: _____

Continuity of Care:

Preferred Pharmacy in Nevada: _____Cross Streets or Phone#: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Employment Information:

Employment: Employed___ Unemployed___ Retired___ Student___

Status: Full Time___ Part Time___ Not applicable___

Employer/Institution: _____

Work Contact #: _____

Can we contact you at work? Yes___ No___ Not applicable___

Can we leave detailed messages on your voice mail? Yes___ No___ Not applicable___

Payment Information:

Is this a self-pay visit? Yes___ No___

Is this visit billed to insurance? Yes___ No___

Primary Insurance: _____ ID #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's Social Security #: _____

Issuing Employer: _____ Customer Service #: _____

Secondary Insurance: _____ ID #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy holder's DOB: _____ Policy Holder's Social Security #: _____

Issuing Employer: _____ Customer Service #: _____

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Name: _____

Bariatric Health History

Name: _____
First Middle Last

Date of Birth: _____Social Security #: _____

Primary Care Physician: _____ Telephone: _____

Weight History: _____ Height: _____ Weight: _____ BMI: _____

How long have you been obese (Lifelong or from what age?): _____

Medical Problems: Please mark Yes | No for the following medical problems that you are being treated for by your physician team.

Arthritis	_____	Hepatitis	_____
Atrial Fibrillation	_____	High Blood Pressure	_____
COPD	_____	High Cholesterol	_____
Diabetes	_____	Sleep Apnea	_____
Heart Disease	_____	-if yes do you use a c-pap ____ bi-pap___	
Heart Arrhythmia	_____		

Please mark Yes | No for any of the items you may suffer from.

Asthma	_____	Pickwickian Syndrome	_____
Deep Vein Thrombosis (DVT)	_____	Polycystic Ovarian Syndrome	_____
Depression	_____	Snoring	_____
GERD	_____	Stroke	_____
Hiatal Hernia	_____	Thyroid Problems	_____
Infertility	_____	Urinary Incontinence	_____
Pancreas Disease	_____	Bowel/Fecal Incontinence	_____
Peptic Ulcer	_____		

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Name: _____

GOVERNMENT REQUIRED INFORMATION

Occupation: _____

Marital Status:

❑ Single	❑ Widowed	❑ Partner
❑ Married	❑ Divorced	❑ Other: _____

Use of alcohol:

Never ____ Yes ____ if yes, amount drinks per day: _____
Former ____ Dates ____/_____/____ to ___/____/____

Number of drinks per day: _____

Use of tobacco:

Never ____ Yes ____ if yes, amount per day: _____
Former ____ Dates ____/_____/____ to ___/____/____

Amount per day: _____

Use of Drugs:

Never ____ Yes ____ if yes, type and amount per day: _____
Former ____ Dates ____/_____/____ to ___/____/____

Type and amount per day: _____

Have you had a Flu vaccine? Yes___ No___ If so, when ____/____/____

Have you had a Pneumonia vaccine? Yes___ No___ If so, when ____/____/____

Have you had any surgeries? Yes___ No___

Name of Surgery: _____Year/Month: _____

Name of Surgery: _____Year/Month: _____

Name of Surgery: _____Year/Month: _____

Name of Surgery: _____Year/Month: _____

Name of Surgery: _____Year/Month: _____

Have you had a colonoscopy? Yes___ No___

If so, who was your GI doctor? _____

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Name: _____

Are you taking any medications? ***Yes_____*** ***No_____***

Name: _____Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Name: _____ Frequency: _____ Dose: _____ Reason: _____

Do you take Aspirin or Coumadin? Yes___ No___

Do You Have any Allergies? ***Yes_____*** ***No _____ (please fill out below)***

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

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Name: _____

FAMILY HISTORY

Please check all that apply, list all relatives and label each with M or P:
(Maternal (M) =Mother's side or Paternal (P) =Father's side)

____ ***Bleeding Disorder***

Type: _____Relatives Affected: _____ (M | P) ____

Type: _____Relatives Affected: _____ (M | P) ____

____ ***Cancer***

Type: _____Relatives Affected: _____ (M | P) ____

Type: _____Relatives Affected: _____ (M | P) ____

____ ***Diabetes***

Type: _____Relatives Affected: _____ (M | P) ____

Type: _____Relatives Affected: _____ (M | P) ____

____ ***Heart Attack***

Relative Affected: _____ (M | P): ____

Relative Affected: _____ (M | P): ____

____ ***Heart Disease***

Relative Affected: _____ (M | P): ____

Relative Affected: _____ (M | P): ____

OTHER IMPORTANT MEDICAL INFORMATION

Yes___ No___ Do you have kidney problems or a single kidney?

Yes___ No___ Have you had cancer or multiple myeloma?

Yes___ No___ Do you have a pacemaker?

Yes___ No___ Have you had any organ transplants?

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Name: _____

GENERAL BARIATRIC DIET HISTORY

What alternative means of weight loss has been used? (Check all the apply)

- ❑ Atkins Diet
- ❑ Weight Watchers
- ❑ Low Calorie
- ❑ Low Fat
- ❑ Low Sugar
- ❑ Low Carb
- ❑ South Beach Diet
- ❑ Jenny Craig
- ❑ Nutrisystem
- ❑ Curves
- ❑ Gym Membership
- ❑ Fit for Life
- ❑ Overeaters Anonymous
- ❑ Prior Weight Loss Surgery
- ❑ Exercise Programs
- ❑ Personal trainer
- ❑ Richard Simmons
- ❑ Jazzercise
- ❑ iMetabolic
- ❑ Liquid Diet/Protein Shakes
- ❑ Sensa
- ❑ Physician Supervised Weight Loss Program
- ❑ Fen Phen
- ❑ Lipozene
- ❑ Meridia
- ❑ HCG
- ❑ Xenical
- ❑ Alli
- ❑ Qsymia
- ❑ Belviq
- ❑ Contrave
- ❑ Other_____

What are problems are you experiencing because of your weight? (Check all that apply)

- ❑ Embarrassment in social situations
- ❑ Problems at work
- ❑ Inability to care for children and family
- ❑ Difficulties with bathing and hygiene
- ❑ Inability to perform activities of daily living
- ❑ Pain in back
- ❑ Pain in feet and ankles
- ❑ Pain in hips and knees
- ❑ Swelling hands and feet
- ❑ Trouble sitting in booths
- ❑ Sitting in a regular size office chair
- ❑ Insomnia
- ❑ Headaches
- ❑ Lower Extremity Edema
- ❑ Malaise/Fatigue
- ❑ Varicose Veins
- ❑ Irregular Periods
- ❑ Dermatitis
- ❑ Not being able to reach a computer keyboard
- ❑ Not being able to fit into a public restroom
- ❑ Getting in and out of bathtub
- ❑ Playing with or caring for children
- ❑ Riding a bike with family
- ❑ Doing yard work
- ❑ Doing housework
- ❑ Taking walks
- ❑ Bending over to pick something up off the floor
- ❑ Having relations

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Name: _____

DIET HISTORY

Please fill out the following lines to the best of your knowledge for diets that you have tried or failed within the last 3-5 years. Please provide documentation for any of the most recent diets attempted within the last 2 years.

Examples of Diets: Akins, Weight Watcher's, Jenny Craig, Physician Supervised, Low Calorie, Low Carbohydrates, Increase of physical exercise, Grapefruit diet, Juice Diet, Fast/Cleanse, pharmaceutical therapies.

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

Date: _____ Diet: _____ Pounds lost: _____ Pounds gained: _____

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Consultation Paperwork

Please bring this completed packet in with you to your consultation.

Please include your insurance card, photo ID, and be prepared with a co-pay for a specialist.

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Insurance Authorization Consent

As a courtesy, K Sasse Surgical Associates, PC will attempt to authorize all radiological procedures and surgeries that may need to be scheduled.

However, as the patient it is ultimately your responsibility to check that Gastric Banding, Gastric Bypass, and/or Vertical Sleeve Gastrectomy is a covered benefit.

Please notify our office immediately of any changes to your insurance coverage or benefits to avoid any delays or out of pocket expenses.

In the event that you do not have bariatric coverage, you will be responsible for all charges due prior to date of service.

Patient Signature: _____

Date: _____/_____/_____

Print Name: _____

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Weight Loss Surgery Practices

Please arrive at K Sasse Surgical Associates, PC with your paperwork filled out, along with one year of medical records. Please feel free to bring along with you any documentation indicating the necessity for weight loss surgery. This may include your doctor's Letter of Support, or any past weight loss programs you may have attended within the last 24 months.

Insurance Requirements: It is your responsibility to determine your benefit coverage prior to your first appointment. At K Sasse Surgical Associates, PC we will do our best to investigate that coverage on your behalf but if for any reason we are not able to we will rely on your knowledge of your insurance plan. If you do find that this is not a covered benefit with your insurance you will be considered a self-pay patient. You will then be responsible for the self pay consultation fee.

Eligibility for Surgery: Insurance companies have specific criteria to follow in order to cover weight loss surgery. In order to verify your eligibility, we must make sure you have followed these insurance guidelines:

1. The acceptable age for weight loss surgery is between18-60. If you are outside of this range we will determine your candidacy on a case-by-case basis, or self pay may be an option.
2. A BMI of 35-39 with one or more co-morbidities (i.e. – diabetes, hypertension, and/or sleep apnea, etc.) A BMI of 40 and above does not require co-morbidities.
3. Psychological Evaluation
4. Nutritional Evaluation
5. Active support from a primary care physician including follow up care.
6. Attendance and participation in all of the bariatric pre-operative classes and appointments in order to understand the commitment to dietary changes, along with the risks and benefits of bariatric surgery. It is your responsibility to be compliant with the costs of these classes & program fee.
7. No active drug or alcohol abuse.
8. No current tobacco use 6-8 weeks prior to surgery.
9. You will be responsible for a Program Fee of $550. This fee covers the Nutritional Class, the Preoperative Class, educational materials that you will receive throughout the process, the running and maintaining of support groups, and all other resources. It is mandatory that this fee be paid upfront and at the time of service.
10. Any estimated out of pocket costs, insurance co-pays, and insurance deductibles must be met and or paid in full prior to surgery.

Authorizations: Our office will attempt to authorize all bariatric preoperative testing and your bariatric surgery. We are only able to authorize your surgery once your items on your Pathway to Surgery Checklist are complete. Once your surgery is authorized Dr. Sasse's surgery scheduler will call you in order to schedule our pre-operative class, pre-operative appointment with Dr. Sasse, your surgery and your postoperative appointment.

Postoperative Plan: After surgery, it will be expected that you follow all postoperative instructions from Dr. Kent Sasse and the other clinical staff members. You may need to follow up with postoperative laboratory work and radiological exams when necessary. It is required that you be seen in our office one week after surgery, and every three months following. This is necessary for your weight loss success.

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Support: At K Sasse Surgical Associates, PC we believe that support can be found in many different forms. Please be aware, there are a lot of myths regarding weight loss surgery and we want to make sure you speak with qualified sources that can help inform you with the correct information. With that said, at Dr. Sasse's office we have support groups that we encourage you to attend pre-operatively and postoperatively.

K Sasse Surgical Associates, PC is committed to providing you with a program designed to help you lose weight with the education and support you need for long-term success. We will maintain confidentially and act in the best interest of our patients. We will keep an open line of communication with our patients and any office staff members. Our team will go far beyond surgery to provide a life-changing program that includes nutritional guidance, support group, and coordination of counseling services. We are dedicated to assisting every patient towards their weight loss goals.

I have read the above and I understand that to be considered for bariatric surgery I must comply with the above Weight Loss Surgery Practices as stated.

Patient Signature: _____

Date: _____/_____/_____

Print Name: _____

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Patient Preferred Communication Form

Our staff may need to contact your regarding your care, because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization to leave detailed messages on voicemails or with designated persons. Please list your authorized contacts below.

I authorize K Sasse Surgical Associates, PC to speak with the following persons:

*Please do not list your physician(s) or yourself.

Name/Relation to Patient	Telephone #	All	Scheduling	Medical	Billing

Emergency Contact: _____

Phone: _____/_____/_____

Relationship: _____

*Patient Signature: _____

Date: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received
(Or Signature of Representative/Legal Guardian)
the Notice of Privacy Practices from K Sasse Surgical Associates, PC.

*Patient Signature: _____

Date: _____/_____/_____

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LIST OF FACILITIES

K Sasse Surgical Associates will schedule and attempt to authorize all procedures/testing, as a courtesy to our patients. Ultimately, it is your responsibility as the patient to know which facilities are contracted with your insurance company. Please check the list of preferred locations below, mark the facilities that are contracted with your insurance carrier(s) and/or the location(s) you prefer. **If you are unsure, please contact your insurance company directly and report the corrected information back to the office.**

Hospitals

- ❑ Renown Regional Medical Center (RRMC)
- ❑ Renown South Meadow
- ❑ Northern Nevada Medical Center
- ❑ Other: _____

Patient Centers:

- ❑ Quail Surgery Center
- ❑ Roseview (Renown Courtyard)
- ❑ Other: _____

Radiology Centers:

- ❑ Renown Imaging Centers
- ❑ Reno Diagnostic Center
- ❑ St. Mary's Hospital
- ❑ Carson Tahoe/GBI/Sierra Surgery
- ❑ Other: _____

Labs:

- ❑ Renown
- ❑ LabCorp
- ❑ Quest
- ❑ Other: _____

I, the undersigned, fully understand that I am responsible for my account, regardless of insurance involvement. KSSA will **NOT** be held responsible if I am scheduled at a non-contracted facility.

Signature: _____ Date: _____/_____/_____

Printed Name: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

K Sasse Surgical Associates, PC

I, _____ to release the following information for the purpose of continuing and/or establishing healthcare:

- ☐ All medical records weight related
- ☐ Specific information as indicated:

  _____
  _____
  _____
  ___

Please send my medical information to:

K Sasse Surgical Associates, PC
75 Pringle Way
8th Floor | Suite 804
Reno, NV 89502

Fax: 775.829.7970
Phone: 775.829.7999

Date of Request: _____

Patient Name (Please Print): _____

Date of Birth: _____

Telephone Number: _____

Patient Signature: _____

Parent/Guardian Signature (if minor): _____

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Consent to Test in the Event of Healthcare Worker Exposure

I have been informed that if a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood-borne disease, my blood will be tested in order to detect whether or not I have antibodies to the Human Immunodeficiency Virus (HIV). This is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood. I also understand that there will be NO CHARGE for the performance of this test. I am encouraged to ask my treating physician any questions regarding the nature of the blood test, its risks, and alternate test, before the test takes place. I understand the result of this blood test will only be made available to the OCCUPATIONAL HEALTH DEPARTMENT for employee follow-up and to my treating physician and will be kept strictly confidential. I understand that I may request the result of the test from my treating physician. I also have been informed that a positive blood test result does not mean that I have AIDS and in order to diagnose AIDS other means must be used in conjunction with the blood test.
.

By my signature below:

- ❑ I acknowledge that I have given consent for the performance of a blood test to detect antibodies for HIV. Authorization is valid until revoked.
- ❑ I refuse to give permission to have the performance of a blood test to detect antibodies for HIV.

Patient Signature: _____
(Or Signature of Representative/Legal Guardian)

Print Patient Name: _____

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K Sasse Surgical Associates, PC is a Teaching Venue

I have been informed that K Sasse Surgical Associates, PC often will have medical students and possible others shadowing with Dr. Sasse or other medical providers. I acknowledge that these students will be a part of the ongoing care team while I am a patient with K Sasse Surgical Associates, PC. As a function of this agreement, I understand that this "shadowing" student may have access to my medical information, but said student will be held to the highest standards with regard to patient information confidentiality. Authorization is valid until formally revoked.

By my signature below:

- □ **I** acknowledge that I have given consent that "shadowing" students may be viewing the care and have access to my protected medical information while under the supervision of Dr. Sasse and the other medical professionals within the scope of the K Sasse Surgical Associates, PC practice. **Authorization is valid until revoked.**
- □ **I** decline this option.

Patient Signature:_____
(Or Signature of Representative/Legal Guardian)

Print Patient Name: _____

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PATIENT FINANCIAL RESPONSIBILITY

Be advised that K Sasse Surgical Associates, PC strives, along with its billing and collection consultant (*WATLAND BILLING*), to assist its patients by filing insurance claims and endeavoring to help its patients understand the financial requirements as they relate to any procedure and/or surgery. In order for our staff to perform these functions successfully, it is imperative that you, the patient, bring the following at your first visit:

- *Current Insurance Card*
- *Photo Identification*
- *Best Mailing Address*
- *Best Phone Number*

PATIENT OBLIGATION: While K Sasse Surgical Associates, PC has contracts with numerous insurance carriers, both Private and Governmental, it is still ultimately the patient's responsibility to understand whether their health plan covers those procedures and/or surgeries being recommended and performed by the practice. Also, please be aware that while K Sasse Surgical Associates, PC and Watland Billing Consultants will make every attempt to help its patients understand the coverage offered by their insurance providers as it relates to any procedure/surgery, it still remains the ultimate responsibility of the patient to insure all appropriate authorizations have been received and notifications given, as required by the health plan in question. It is also the patient's responsibility to understand, and pay any applicable co-payments, co-insurances, deductibles, or other amounts that may be rendered up to the total extent that those services are not covered by the contract in place between the practice and the health plan, whether Private or Governmental. It is also the patient's responsibility to inform K Sasse Surgical Associates, PC of any billing or medical insurance changes. X_____

COMMERCIAL INSURANCE: K Sasse Surgical Associates, PC will bill commercial insurance carriers and send a statement showing any remaining balances. If your insurance does not pay within 60 days, the balance will be your (the patient's) ultimate responsibility. Please be advised that K Sasse Surgical Associates, PC may not fully recognize usual and customary discounts suggested by your carrier.
X_____

MEDICARE: K Sasse Surgical Associates, PC will bill Medicare and Medicare-Gap insurance carriers. If Medicare or an affiliate does not pay within 30 days, the balance will be your (the patient's) ultimate responsibility. X_____

MEDICAID: K Sasse Surgical Associates, PC will bill Medicaid. Please plan on bringing your Medicaid card at each and every visit. K Sasse Surgical Associates, PC is not able to bill without it. X_____

COLLECTION POLICY: Please expect that you will receive not less than two (2) statements and one (1) phone call to address any balances due. If payment arrangements are not made within this time frame, the balance due will be forwarded to a Collection Service. *SHOULD YOU NOT HAVE PAYMENT AVAILABLE IN FULL; ARRANGEMENTS CAN BE MADE* ***SO PLEASE WORK WITH US****.*
X_____

PAYMENTS: K Sasse Surgical Associates, PC ***DOES NOT ACCEPT CASH***. Payment may be made by credit/debit card, personal check, cashier's check, or money order. X_____

RETURNED PAYMENTS: There will be a $25.00 charge for returned payments. X_____

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SELF-PAY PATIENTS (NON-BARIATRIC): Please be prepared to pay a minimum of $100.00 deposit for each office visit. K Sasse Surgical Associates, PC will bill for any additional balances. For surgical procedures, a $500.00 deposit is required before surgery can be scheduled. Payment plans and financing are available. X_____

MISSED APPOINTMENT POLICY: We understand the need, at times, to cancel your appointment. If you must cancel, please give us at least 24 hours' notice. Should you fail to attend your appointment without calling or giving us less than 24 hours' notice of cancellation you will be charged $50.00. X_____

MISCELLANEOUS: There is a charge of $25.00 for our office to complete one (1) set of FMLA paperwork. For each additional set of paperwork that needs to be completed there will be a charge of $15.00. Should you request copies of your medical records there is a charge of 60¢ per page. There is no charge for medical records requested by your other physician team. X_____

PATIENT/AUTHORIZED PERSON'S SIGNATURE: By signing below, I am authorizing K Sasse Surgical Associates, PC to release any of my medical information that may be necessary to process my insurance claims, payments, and/or to any other physician/facility that may be required in the overall course of patient care. I further authorize K Sasse Surgical Associates, PC to obtain medical information from any source deemed necessary for my treatment. X_____

I additionally authorize my medical benefit payments to K Sasse Surgical Associates, PC for all services rendered. If for any reason, payment is made directly to you, the patient, you will authorize the payment either through endorsement or by issuing a new payment to K Sasse Surgical Associates, PC in the amount due. Patient also agrees to pay all attorney and/or collection fees should collection proceedings become necessary. By signing below, it is also understood that a charge of $25.00 will be assessed for any unpaid or otherwise dishonored checks that are returned. Please note that a copy of this authorization shall be considered effective and valid for one (1) year after the date posted below.

Patient Signature: _____

Date: _____/_____/_____

Printed Patient Name: _____

PARENTAL CONSENT TO TREAT A MINOR:

Child's Name: _____

I, _____, do hereby provide consent to K Sasse Surgical Associates, PC, the right to evaluate and treat the above described child, under the same terms and conditions listed in the agreement above.

Parent Signature: _____ Date: _____/_____/_____

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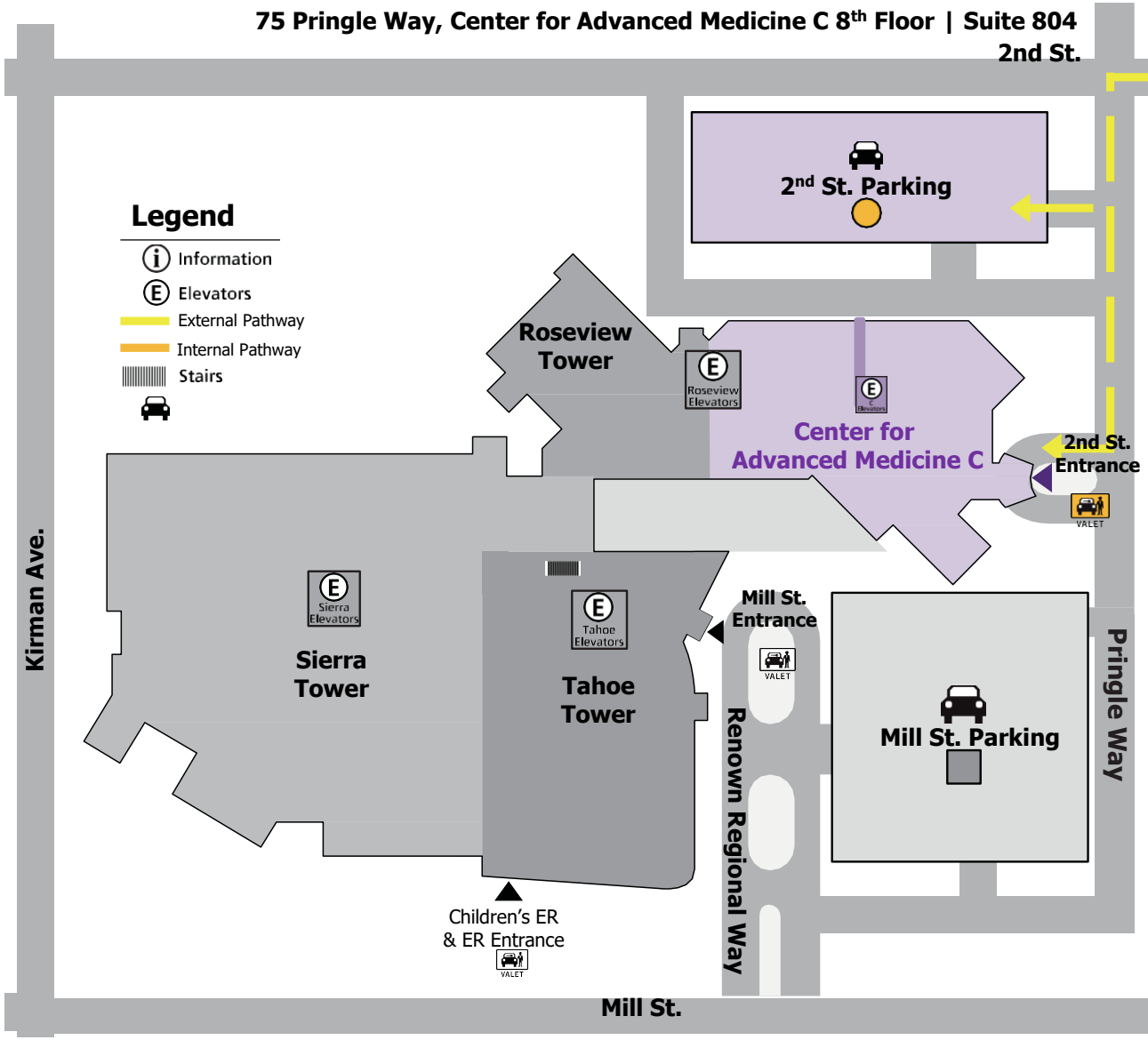
Kent C. Sasse, M.D.,

MPH, FACS, FASCRS, FASMBS

75 Pringle Way, Center for Advanced Medicine C 8th Floor | Suite 804



Driving Directions:

1. Exit at Glendale | E. 2nd St. (exit 66).
2. From US 395 northbound, turn left. From US 395 southbound, turn right.
3. Cross Kietzke Lane.
4. Turn left at Pringle Way.

Parking:

- Valet Parking is available for a nominal fee at the 2nd St. Entrance.
- Self-parking is available in 2nd St. Parking.
- Take C Elevators to the 8th Floor | **Suite 804.**

K Sasse Surgical Associates, PC | 75 Pringle Way, 8th Floor, Suite 804 | Reno, NV 89502 | 775.829.7999 (p) | 775.829.7970 (f) | www.sassesurgical.com
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