Medical Weight Loss Clinic

Check all that apply to you:

1.___ Do you suffer from any unwanted pain, if so what location or area of the body?

_____

2.___ Do you have any unwanted scars or stretch marks, if so what location of the body?

_____

3.___ Do you suffer from any allergies or have you ever thought at any point if you may have any allergies to any foods of any kind?
Please explain.

_____

_____

Do not fill out this portion (physician only)

Name:_____ Dob:_____

Telephone #_____

Address:_____ City:_____ State:_____

Medication allergies:_____

List of medications:_____

Email:_____

Insurance:_____

Bin#_____

Group#:_____

Patient Registration Form

Patient Information

Last Name	First Name	Middle Name
Date of Birth	Social Security #	Primary Care Provider

Mailing Address | City, State | Zip Code

Street Address (if different from above) | City, State | Zip Code

Primary Phone #	Secondary Phone #	E-mail Address
Sex	Marital Status	Race
Language	Ethnicity	Occupation

Employer | Employer Phone #

Employer's Address | City, State | Zip Code

Spouse Information

Spouse's Name	Date of Birth	Social Security #

Employer | Employer Phone #

Employer's Address | City, State | Zip Code

Patient Name:_____ Date of Birth:_____

Emergency Contact *(a relative or friend)*

Name	Relation to Patient	Primary #

Information

Insurance Company	Subscriber Name	Relation to Patient
Date of Birth	Social Security #	Employer Name

Secondary Insurance (if any)	Subscriber Name	Relation to Patient
Date of Birth	Social Security #	Employer Name

Parent/Legal Guardian Information *(if patient is under 18 years of age)*

Guarantor's Name	Relation to Patient	Social Security #
Date of Birth	Primary Phone #	Secondary Phone #

_____

Address (if different from above) City, State Zip Code

_____

Employer Employer Phone #

_____

Employer's Address City, State Zip Code

Name of Adult Presenting Child for Treatment (if different from above)	Relation to Patient

Who may we thank for referring you to our office? OR How did you hear about our office? _____

_____ _____

Patient Signature **Date**

_____ _____

Parent/Legal Guardian Signature *(if patient is under 18 years of age)* **Date**

Please give the receptionist your insurance card(s) and Driver's License.

We appreciate your business.

Medical History

Patient Name:_____ Date of Birth:_____

Please take a few moments to fill out our health history form. Fill in ALL areas, to the best of your knowledge. Your answers will help the provider plan and provide your care.

Patient Information

Patient Name	Date of Birth	Today's Date
Pharmacy Name	Pharmacy Location	Pharmacy #

Current Medical History (please circle all that apply)

Acid Reflux/GERD
Addiction
Anemia
Angina
Arthritis
Asthma
Bleeding Disorder
Blood Clot
Bleeding Disorder
Blood Clot
Cataracts
Circulatory Disorders (PAD/PVD)
Colon Disease
COPD/Emphysema
Dementia
Depression/Anxiety
Diabetes Mellitus
HIV/AIDS
Heart Valve disorder
Heart Attack (MI)
Heart Disease
Heart Murmur
Hepatitis_____
Hyperlipidemia (High Cholesterol)
Hypertension (High Blood Pressure
Irritable Bowel Syndrome (IBS)
Kidney Disease
Liver Disease
Migraine
Pacemaker
Osteoporosis
Seizures/Epilepsy
Skin Disease
TIA/CVA (Stroke)
Thyroid Disease

Cancer if yes, what type?_____ currently under treatment? O No O Yes
Mental Illness if yes, what type?_____ currently under treatment? O No O Yes
Other not listed:_____

Hospitalizations/Surgeries (please provide date of procedure)

_____

_____

_____

_____

Patient Name:_____ Date of Birth:_____

Family History (please ✓ all that apply and list family members that apply)

Alcoholism O Mother O Father O Sibling O Child O Other:_____
Anemia O Mother O Father O Sibling O Child O Other:_____
Asthma O Mother O Father O Sibling O Child O Other:_____
Blood Disorder O Mother O Father O Sibling O Child O Other:_____
Cancer O Mother O Father O Sibling O Child O Other:_____ What kind?_____
Cerebral Infarction (Stroke) O Mother O Father O Sibling O Child O Other:_____
Dementia O Mother O Father O Sibling O Child O Other:_____
Diabetes O Mother O Father O Sibling O Child O Other:_____
Genetic Disease O Mother O Father O Sibling O Child O Other:_____
Heart Attack <50 years O Mother O Father O Sibling O Child O Other:_____
Heart Disease O Mother O Father O Sibling O Child O Other:_____
Hyperlipidemia (High Cholesterol) O Mother O Father O Sibling O Child O Other:_____
Hypertension (High Blood Pressure) O Mother O Father O Sibling O Child O Other:_____
Kidney Disease O Mother O Father O Sibling O Child O Other:_____
Mental Illness O Mother O Father O Sibling O Child O Other:_____
Osteoporosis O Mother O Father O Sibling O Child O Other:_____
Seizures/Epilepsy O Mother O Father O Sibling O Child O Other:_____
Thyroid Problems O Mother O Father O Sibling O Child O Other:_____
Other:_____O Mother O Father O Sibling O Child O Other:_____

Social History (please ✓ and answer all that apply)

Tobacco use O Never O former 0 current Packs/day____# of years_____quit?
Alcohol/beer use O Never O occasional/social drinker–_____# of drinks per day ?
Street drug use O None O other use?_____
Caffeine use O No O Yes_____# of cups per day?
Exercise O Sedentary O Light O Moderate
Marital status O Married O Divorced O Widowed O Single
Employment Current job/occupation?_____
Sexually active O No O Yes

Women's Health History (please ✓ and answer all that apply)

Last menstrual period_____Cycles Regular?_____ Average cycle duration_____Pain associated_____
Has menopause started/occurred? O No O Yes–what age?_____
Number of total pregnancies____ Full Term?_____ Trying to conceive?_____ Could you be pregnant now?_____
Date of last annual exam?_____ Last mammogram?_____
Birth control: O None O Yes– O birth control pill O Depo-Provera O IUD 0 Other:_____

Medical History

Allergies (please list all allergies and the type of reaction)

Patient Name:_____ Date of Birth:_____

Allergy	Type of reaction
Example: *Sulfa*	*rash*

Current Medications (please list all medications, including over the counter vitamins and supplements)

Medication	Dosage	Taken how often?	Provider name
Example: *Lasix*	*20mg*	*twice per day*	*Dr. Jones*

Depression Screening

Over the past two (2) weeks, I have had little interest or pleasure in doing things. O No O Yes

Over the past two (2) weeks, I have felt down, depressed or hopeless. O No O Yes

Under the care of any health care providers?_____

Patient Name:_____ Date of Birth:_____

I. Procedures and Alternatives

_____ I have read and understand the following statements:

1. All prescription medications, including appetite suppressants, have labeling approved by the Food and Drug Administration (FDA). This labeling found on most appetite suppressants is based upon medical studies of less than twelve weeks using the dosages indicated on the labels.
2. Notwithstanding such labeling, I understand that my physician, based upon his experience, the experience of his colleagues and other factors, may recommend the use of such medications for a period of time or at doses in excess of those recommended by the manufacturer's label. I further understand that such usage may not have been as systematically studied as that suggested by the labeling, and it is possible, as with many other medications, that serious side effects could occur.
3. After consulting my physician, I believe that the probability of such side effects is outweighed by the potential benefit of the appetite suppressants being prescribed and/or provided to me, notwithstanding the fact that the dosage and/or term may exceed those recommended by the manufacturer.

_____ I understand that it is my responsibility to follow my physician's instructions carefully and to report any medical problems immediately, regardless of whether I think that they may be related to my weight loss control program. I further affirm that I am not now pregnant and will report any pregnancy to my physician immediately.

_____ I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain my weight loss. In particular, a balanced diet combined with physical exercise is recommended, with or without the use of appetite suppressants. I understand that a program including a revised diet and physical exercise could prove successful without appetite suppressants if I followed it, even though I may be hungrier than if I used the appetite suppressants.

II. Risk of Proposed Treatment

_____ I understand that this authorization is given to me with the knowledge that the use of appetite suppressants poses various risks, including , but not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medical allergies, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could occasionally be serious or even fatal.

III. Risks Associated with Being Overweight or Obese

_____ I understand that remaining overweight or obese poses certain risks, including tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis, and certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.

IV. No Guarantees

_____ I understand that much of the success of this program will depend in my efforts. Notwithstanding my efforts, I understand that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to successful long term.

V. Payment, Insurance, Refunds and Prescriptions

Patient Name:_____ Date of Birth:_____

_____ By consenting to treatment, I agree to pay in full for all visits and charges at the time of each visit. I understand that not all services are reimbursed by insurance and that you do not provide or complete claim forms for insurance purposes. I understand that no refunds are given at any time for any reason. I understand that medications could dispensed to me during my monthly visits and are included for quality assurance and convenience; however, in most cases, I will be given a written prescription for my monthly dose of medication.

VI. Patient Consent

_____ I have read and fully understand this consent form, and I have had all concerns addressed by the physician. Moreover, I have been informed by my physician of the nature, risks, possible alternative treatments, possible consequences and possible complications involved in the use of appetite suppressants for the treatment of obesity and weight loss. Nevertheless, I authorize my physician to administer the treatment to me.

VII. Pregnancy Waiver

I hereby acknowledge that Medical Weight Loss has informed me prior to receiving treatment of the advisability of risk and the probable consequences of treatment during pregnancy. By my signature below, I confirm that I am not pregnant at the time and do hereby release and hold harmless Medical Weight Loss and any health care provider from any legal action or responsibility caused by treatment. If I become pregnant, I will notify Medical Weight Loss immediately.

_____ _____

Patient Signature (or Guardian signature, if patient is a minor) Date

Consent and Disclosure of Health Information for Medical Treatment

_____

Patient Name (printed)

(please initial by each)

_____ I understand that as part of my healthcare plan, Medical Weight Loss must originate and maintain health records describing my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future care or treatment.

_____ I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis to my bill;
- A means by which a third party can verify that services actually billed were provided; and
- As a tool for routine healthcare operations such as assessing quality and review the competence and documentation of healthcare professionals.

_____ I understand that I have the option of receiving a copy of the Privacy Notification that provides a more complete description of use of personal information and applicable disclosures.

_____ I understand that I have a right to review the Privacy Notification prior to signing this consent form.

_____ I understand that Medical Weight Loss reserves the right to change its Privacy Notification and privacy practices.

_____ I understand that prior to implementation of any changes, Medical Weight Loss will mail a copy of any revised Privacy Notification to the mailing address provided, should I request.

_____ I understand that I have the right to object to the restrictions as to how my health information may be used or disclosed to carry out treatment, requests for payment, or healthcare operations. Medical Weight Loss is not required to agree to the restrictions requested.

_____ I understand that I may revoke my consent in writing, except to the extent that Medical Weight Loss has already taken action in reliance of such consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Witness Date

8/2016

Annual Consent/Authorizations
(HIPAA)

Patient Name:_____ DOB:_____

Consent for Treatment:

- Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, or Nurse Practitioner.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:
Tell us with whom we may discuss your protected health information:
(Name and relation--EX. Jane Doe, wife)

1. _____
2. _____
3. _____

If you do not authorize information to be released to anyone please check the statement below.

☐ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine.
Below, please indicate the numbers our staff can utilize to leave a message for you:

1. _____
2. _____
3. _____

Financial responsibility:
I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Medical Weight Loss, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Medical Weight Loss, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Medical Weight Loss or payment for the services I received at Medical Weight Loss including but not limited to debt collection purposes.

I acknowledge that I have read the above, and am giving my consent to the above.

_____ _____
Patient Signature Date

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

_____ _____

Patient's Signature Date