MEDICAL WEIGHT LOSS

New Patient Questionnaire (Health Care Analysis)

First Name_____ Last Name _____ Email_____

Address _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ DOB_____

Age_____ Height_____ Weight_____ Gender Male - Female

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Employer Phone Number_____

Insurance Company _____ Your Social Security # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Parent _____ Their Birth date _____

Spouse Employed By _____ Occupation _____Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____

Does your spouse have health insurance at work? Yes _____ No _____

How did you hear of **Medical Weight Loss Centers, LLC :** _____

If referred by someone, who? (Please name) _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

I hereby assign, transfer, and set over to **Medical Weight Loss Centers LLC** all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____**Date:**_____

Or Guardian Signature _____**Date:**_____

Patient Questionnaire

How long have you been overweight? _____

How much weight have you decided to lose? _____

How many times have you failed at weight loss? _____

What methods failed to help you lose weight? _____

Does your weight problem make you physically uncomfortable (explain)? _____

Does your excessive weight limit you and your activities (explain)? _____

How many times a year do you diet? _____

Do you suffer from uncontrollable cravings (explain)? _____

Do you feel out of control? _____

Do you eat because of emotions (explain)? _____

Are you embarrassed about your weight? _____

Is successful weight loss a top priority (explain)? _____

Will you purchase a new wardrobe when you lose weight? _____

What new activities will you become involved in after losing weight? _____

Are other members of your family overweight? _____

Briefly describe your eating behavior? _____

Do you believe weight loss has to be painful? _____

Do you believe weight loss can be enjoyable? _____

How fast do you want to be thin, trim, and fit? _____

Do you feel you're eating behavior is normal? _____

Does your family support your weight loss efforts? _____

Does being overweight limit your social life? _____

Do you feel tired, run down, and out of energy? _____

Can you remember being your ideal weight? (Explain) _____

Has being overweight caused you pain and suffering (describe physical and emotional pain)?

_____

_____

Circle the most important element in deciding to use our services (circle one):

Effectiveness (your results)

Time (how fast you get results)

Service (how we respond to your needs)

Affordable (what we charge)

Current Medications: Prescriptions Only

Medication/Dose/How often	Reason for Taking	Prescribing M.D.

HIPAA FORM

Introduction

At **Medical Weight Loss Centers, MWLC LLC *** we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which **MWLC LLC*** is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures **MWLC LLC*** may contact patients with appointment reminders, requests for the patient to contact**, MWLC LLC*** for appointments, notices and letters concerning medical findings. **MWLC LLC*** may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; updated April 10, 2008.

Individual Rights

Although your health record is the physical property of **MWLC LLC***, the information belongs to you. You have the right to:

1 The right to request restrictions on certain uses and disclosures of your information;
2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3 The right to receive confidential communications;
4 The right to obtain a copy or inspect your health information;
5 The right to amend protected health information;
6 The right to receive an accounting of disclosures of protected health information.

MWLC LLC* Center's Rights

1. **MWLC LLC *** has 30 days with which to comply with a patient's request to review or copy their health information. **MWLC LLC*** is allowed an additional 30 days if the record is off site. **MWLC LLC*** may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;

3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. **MWLC*** will charge staff time for this service.

MWLC* Medical Center's Duties

1. **MWLC*** is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. **MWLC*** is required to abide by the terms of this Notice; and
3. **MWLC*** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201.

Further Information-Please contact the SMC administrator at 747-5861 for further information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Witness Signature (Check In)_____ Date:_____

PATIENT'S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I without reservation waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

I understand that if I lose my medications, which are handed out on a bi-weekly or monthly basis, I will not be able to obtain a new supply until the following office visit whether it be bi-weekly or monthly. As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

Please be advised that MWLC LLC requires that all patients have a yearly diet panel drawn to give us a thorough perspective of our patient's general health. We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit, and will not disperse any further medications until this is done. However, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient signature: _____ Date: _____

Patient Printed name: _____