Patient Registration

Office Use Only

Chart:

Date:

□ Entered

Entered By:

□ Mr. □ Miss Last Name: First: Middle: □ Single □ Married
□ Mrs. □ Ms. □ Divorced □ Separated
□ Dr. □ Widow(ed) □ Partner

Gender: Birth Date: Age: SSN: Email Address:
□ M □ F / /

Address: Address (2):

City: State: Zip:

Phone Number: Mobile Number: Fax Number:
( ) ( ) ( )

Occupation: Employer: Work Number:
( )

May we…

Call you?
□ Yes □ No

Email you?
□ Yes □ No

Send you mail?
□ Yes □ No

How did you hear about us?
□ Billboard □ Coupon □ Direct Mailing □ Employee □ Internet □ MD/Doctor □ Magazine
□ Newspaper □ Patient/Friend □ Radio □ TV □ Walk-In □ Other:

Do you know anyone else on our program? If so, who?

Which doctor, if any, referred you?

Emergency Contact

Local Friend/Relative: Relationship: Phone Number: Work Number:
( ) ( )

Insurance Information

Medical insurance policies typically do not cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication, and related supplements. Your primary diagnosis is overweight or obesity.

An appropriate receipt of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies.

Changes to "codes" will not be made for the use of any insurance company. Insurance companies may reimburse patients for expenses related to weight management; for instance, if weight management is part of the treatment of a comorbid condition.

Reimbursement will not be made from the insurance company to the physician. Please note that Medi-Weightloss will not present a bill to any insurance company for weight management services or related charges. Also, Medi-Weightloss will provide what is considered an appropriate receipt, as described, and is not obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard.

If you are covered by Medicare you must complete and sign an ABN form prior to participation in this Weight Management Program.

Medicare Beneficiary

Are you currently a beneficiary of Medicare? □ Yes □ No

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in Medi-Weightloss Weight Management Program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: Date:

Printed Name: If guardian, list relationship to the patient:

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Patient History

Office Use Only	
Chart:	
Date:	
Revisions:	

All questions contained in this history form are strictly confidential and will become part of your medical record on file.

Last Name: First Name: Middle: Gender: Birth Date: Age:

□ M □ F / /

Primary Physician/Referral: Physician Phone Number:

( )

Optometrist/Ophthalmologist: Ophthalmologist Phone Number:

( )

Weight:

Last Physical: Last EKG: Last Eye Exam:

Goal Weight:

Health History

Complete to the best of your knowledge.

Are you under a doctor's care at the present time? □ Yes □ No If yes, for what?

	Family	Personal		Family	Personal		Family	Personal
Alcohol Abuse	□	□	Drug Abuse	□	□	Irregular Pulse	□	□
Anemia	□	□	Eating Disorder	□	□	Kidney Disease	□	□
Arthritis	□	□	Epilepsy	□	□	Liver Disease	□	□
Asthma	□	□	Fainting Spells	□	□	Lung Disease	□	□
Bleeding Disorder	□	□	Fatigue	□	□	Mental Illness	□	□
Bloody Stool	□	□	Food Allergies	□	□	Migraines	□	□
Bronchitis	□	□	Frequent Urination	□	□	Moodiness	□	□
Cancer	□	□	Gallbladder Disorder	□	□	Nervousness	□	□
Chest Pain	□	□	Glaucoma	□	□	Obesity	□	□
Constipation	□	□	Gout	□	□	Palpitations	□	□
Convulsions	□	□	Headaches	□	□	Rashes	□	□
Depression	□	□	Heart Disease	□	□	Shortness of Breath	□	□
Diabetes	□	□	High Cholesterol	□	□	Sleep Apnea	□	□
Diarrhea	□	□	Hypertension	□	□	Stroke	□	□
Dizzy Spells	□	□	Insomnia	□	□	Thyroid Disease	□	□

Comments/Other:

Surgeries & Other Hospitalizations

Year	Reason / Diagnosis	Hospital

Medication Allergies

□ No Known Allergies

Medication Name	Reaction

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Prescribed Medications, over-the-counter drugs, dietary supplements (inc. vitamins, inhalers, etc)		Chart:
Medication Name	Strength	Frequency

Behavior Style

Please mark only one answer.

- □ You are always calm and easygoing.
- □ You are usually calm and easygoing.
- □ You are sometimes calm and easygoing
- □ You are seldom calm and persistently driven to advance
- □ You are never calm and have overwhelming ambition
- □ You never let yourself relax.

Health Habits & Personal Safety

This section is optional. All answers will be kept strictly confidential.

Exercise	□ Sedentary (no exercise)				
	□ Mild Exercise (i.e., climbing stairs, walking three blocks, golf)				
	□ Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)				
	□ Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)				
Diet	Are you dieting?			□ Yes	□ No
	If yes, are you on a physician-prescribed medical diet?			□ Yes	□ No
	How many meals do you eat in an average day?				
	Rank your salt intake:		□ High	□ Medium	□ Low
	Rank your fat intake:		□ High	□ Medium	□ Low
Caffeine	Rank your caffeine intake:	□ High	□ Medium	□ Low	□ None
	What types of caffeine do you drink?		□ Coffee	□ Tea	□ Soda
	How many cups/cans per day?				
Alcohol	Do you drink alcohol?			□ Yes	□ No
	If yes, what kind?		□ Beer	□ Liquor	□ Wine
	How many drinks per week?				
Tobacco	Do you use tobacco?			□ Yes	□ No
	□ Cigarettes – packs/day:	□ Chew – #/day:	□ Pipe – #/day:	□ Cigars – #/day:	
	How many years?				
	If you previously used tobacco, what year did you quit?				
Drugs	Do you currently use recreational or street drugs?			□ Yes	□ No
	Have you ever taken street drugs with a needle?			□ Yes	□ No
Sex	Are you sexually active?			□ Yes	□ No
	If yes, are you trying for a pregnancy?			□ Yes	□ No
	If you are not trying for a pregnancy, what contraceptive methods are you using?				

Women Only

How old were you at onset of menstruation?	Date of last menstruation?	Date of last GYN visit:		
How often do you get your period (days)?	Number of Pregnancies:	Number of live births:		
Heavy periods, irregularity, spotting, pain, or discharge?			□ Yes	□ No
Are you pregnant, trying for pregnancy, or breast feeding?			□ Yes	□ No

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Weight History	Chart:

1. What is the main reason you decided to lose weight?

2. When did you begin gaining excess weight? Provide reasons if known.

3. What do you think is the main cause of your weight problems?

4. Describe your previous attempts at weight loss or previous diets you have followed. Provide dates and results if possible.

5. Is your spouse, fiancé/fiancée, or partner overweight? If so, by how much?

6. How often do you dine out?

What restaurants do you frequent?

What types of food do you eat there?

How often do you eat *fast food*?

7. List any food allergies:

8. What foods do you avoid?

9. What foods do you crave?

10. Do you wake up hungry during the night?

If so, what do you do?

11. What are your worst food habits?

12. What are your snack habits?

13. Rate your body from 1 to 10. How would you describe your body?

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14.	If you could change one thing about your body, what would it be?
15.	Do you tend to eat more when you are under a stressful situation? Explain:
16.	Do you think you are currently experiencing a stressful situation or emotional upset? Explain:
17.	What do you feel will be your obstacle(s) to successful weight loss?
18.	What is your typical breakfast? What time? Where? With whom?
19.	What is your typical lunch? What time? Where? With whom?
20.	What is your typical dinner? What time? Where? With whom?
21.	Who plans meals? Cooks? Shops?
22.	Do you use a shopping list when buying groceries?
23.	Add any additional comments you think would be helpful to the doctor.

Accuracy Agreement	
I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.	
Signature:	Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.

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Medi-Weightloss™ HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment

We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used as needed to obtain payment for your health care services.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses and Disclosures

Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Individual Rights:

1. **You have the right to inspect and receive a copy of your protected health information**. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction on the disclosure of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by an alternative means or at an alternative location**.

4. **You have the right to obtain a paper copy of this notice from us**.

5. **You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information**. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Complaints

You may file any complaints with our Privacy Officer, Macklin E. Guzmán, MPH, at (813) 228-6334, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

Medi-Weightloss™ Receipt of Notice of Privacy Practices		Chart:
Medi-Weightloss™ reserves the right to modify the privacy practices outlined in this notice. By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for **Medi-Weightloss™.**		
Printed Name:	Patient Signature:	Date:

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Medi-Weightloss™ Authorization to Release and Disclose Protected Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we communicate with you directly regarding various issues including, but not limited to, our products and/or services we currently offer or which we intend to provide, promotions and/or prizes. This form authorizes us, as well as our business associates who are working on our behalf, to utilize your protected health care information, such as your name, address, email, and phone number, to communicate with you. You are not required to sign this authorization as a condition of eligibility for enrollment and treatment under Medi-Weightloss™ weight loss and weight-management program.

This authorization is completely voluntary and shall remain in effect until thirty six (36) months after your last visit. You may revoke this authorization at any time by notifying our Privacy Officer, Macklin E. Guzmán, MPH, at (813) 228-6334 or in writing at 509 S. Hyde Park Blvd, Tampa FL 33606. However, the revocation will not be effective to the extent that we have already acted in reliance on this authorization.

By signing below, you are acknowledging that you have read this authorization carefully and you are authorizing us to utilize your confidential protected health information to communicate with you. You understand that by communicating with you through mail, email or by phone there is a potential for your protected health care information to become re-disclosed and utilized by the recipient without your knowledge or consent and therefore the privacy of your personal and health information will no longer be protected by federal privacy regulation.

Authorization to Release and Disclose Protected Health Information Version A1		Chart:
Printed Name:	Patient Signature:	Date:

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Date: _____

Re: _____ DOB: _____/_____/_____

Faxed to: _____

MEDI WEIGHTLOSS™
The one that works!®

Dear _____:

Your patient, _____, recently presented for a consultation and is interested in participating in our physician-supervised weight loss program. The **Medi-Weightloss™** Program is customized for each patient and includes weekly, often biweekly, consultations with our medical team that focus on nutrition, behavior modification, and physical activity. Our program includes a line of supplements specifically formulated to ensure effective weight loss and sound nutrition while on a very low-calorie, protein-sparing diet.

The Initial Consultation includes a comprehensive blood panel, blood pressure reading, EKG, weight and body fat analysis, physical examination, and a review of the patient's medical history. Patients that are deemed appropriate candidates for treatment may also be prescribed an oral appetite suppressant medication such as Phendimetrazine or Phentermine. Our office adheres to the anorectic guidelines provided by the American Society of Bariatric Physicians.

Our evaluation revealed that while your patient meets the criteria for the **Medi-Weightloss™** Program, he/she has the following condition(s) based upon history and/or current examination:

_____

_____

We are hereby requesting your opinion as to whether your patient has any medical contraindications to participate in our program. Throughout his/her participation and with the patient's consent, our office will provide you copies of medical records to ensure you are informed on your patient's progress. Please complete this form and fax it to us at _____.
If you have any questions, please contact me directly at _____.

Sincerely,

Print Name: _____

After review of the medical conditions and other pertinent information,_____

- ☐ Is an acceptable candidate for participation on the **Medi-Weightloss™** Program.
- ☐ Is an acceptable candidate for participation on the **Medi-Weightloss™** Program with the following exceptions:_____
- ☐ Is not an acceptable candidate for participation on the **Medi-Weightloss™** Program.

Signature: _____ Date: _____

Print Name: _____

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