HAZELWOOD FAMILY MEDICINE
1088 Brown Avenue
Waynesville, NC 28786
828-456-2828

Medical Weight Loss Clinic

Sample

Dear Patient,

Thank you for scheduling an appointment with our medical weight loss clinic. Enclosed you will find your new patient paperwork. Please complete all the information and bring it with you to your first appointment. We ask that you arrive at least 15 minutes prior to your scheduled appointment to review your paperwork and to help keep appointments on time.

If you would like for us to file this visit with your insurance company, we will be more than happy to do so. However, it is *your* responsibility to check with your insurance company to see if weight loss is covered under your policy.

Please inform our reception staff and myself if your insurance will not cover the visit. If your policy does not cover weight loss, your first appointment will cost $200 (including labs) plus the additional cost of any medications. Subsequent appointments will cost $100 plus medications. Unfortunately, Hazelwood Family Medicine has no control over the specifics of what your insurance will or will not cover. Please know that payment is expected at the time your services are rendered. We will accept cash or credit cards only…no checks please.

Dr. Brown and I look forward to helping you meet your weight loss goals! If you have any questions at all please do not hesitate to ask our staff.

Sincerely,

Carrie Mehaffey

Carrie Mehaffey, CMA
Weight Loss Clinic Coordinator

WELCOME

HAZELWOOD FAMILY MEDICINE
1088 Brown Avenue - Waynesville, NC 28786
Telephone: (828) 456-2828 - Fax: (828) 456-8903

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Email _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE

I request that payment of authorized Medicare benefits be made either to me on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

3 PHONE NUMBERS

Home _____ Work _____ Ext. _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ❑ ❑	Present health or cause of death	MOTHER ❑ ❑	Present health or cause of death	SPOUSE ❑ ❑	Present health or cause of death

BROTHERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES ❑ Diabetes ❑ Cancer ❑ Bleeding tendency ❑ Kidney disease ❑ Tuberculosis ❑ Heart disease ❑ Stroke ❑ High Blood Pressure ❑ Nervous illness ❑ Allergy ❑ Other

Weight Loss Program Consent Form

I _____ authorize Dr. Michael Brown and whomever he may designate as his assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. Rapid weight loss can increase the risk of gallstones, and there is a possibility that I could require surgery for gallstones, especially with rapid weight loss. These and other possible risks could, on occasion, be serious or even fatal.

Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.
If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Patient _____ **Date**

Witness _____

HCG INJECTION WAIVER

I understand that with the HCG injections, there are no guarantees as to how much weight I may lose. I understand that weight loss results vary with each individual.

I understand that the HCG injections are designed for individuals who are in a physical condition acceptable for the HCG injection requirements. I verify that I am in acceptable physical and mental health and that I have discussed the HCG injections with my physician and that he/she has given me permission to proceed with the HCG injections as outlined.

I understand that though it is not likely, it is possible to experience minor side effects. I understand that HCG is NOT FDA approved for weight loss. I understand that should I experience any unusual, unexplainable or unexpected symptoms, I will discontinue the program immediately and contact Hazelwood Family Medicine.

Initials Required

Female only: I verify that I am NOT pregnant, NOT trying to get pregnant and NOT nursing a baby(s).

By my signature, I certify that I am at least 18 years of age, I acknowledge that I have read and understand the above, have not been coerced in any way, I was made no promises about weight loss amounts, and do state that I want to participate in the weight loss program with Hazelwood Family Medicine with this understanding.

Name Date

Date of Birth

Email