



Chesapeake Weight Loss Consultants, PLLC
 Medical and Aesthetic Solutions

Administrative Data Sheet

Patient Information:

Name _____, _____ SSN _____
Last/Surname First Middle

Address _____
Street number/Apt. City State Zip Code

Date of Birth _____ Gender: _____ check preferred telephone number: Home _____

Mobile _____ ok to txt appt reminders (circle)? Yes No Work _____

May we leave telephone messages about medical appointments (circle)? Yes No Non-sensitive lab results (circle)? Yes No

email _____ Employer Name _____

Employer Address _____

Next-of-Kin/ Emergency Contact information:

Relationship to you _____

Name _____, _____
Last/Surname First Middle

Address _____
Street number/Apt. City State Zip Code

Home Telephone _____ Mobile Telephone _____

Primary Care Provider information

Name _____ Address _____

Phone _____ Fax _____

Insurance Information:

Name of Policy Holder (if other than self) _____

Policy Holder SSN _____ Policy Holder Date of Birth _____

Primary Insurance _____ Group # _____ Policy # _____

Secondary Insurance _____ Group # _____ Policy # _____

Insurance Assignment: I authorize the filing of insurance claims to any policies in force at the time of services rendered, as well as direct payment to Chesapeake Weight Loss of any amounts due. I understand that my insurance policy is a contract between me and my insurance company, and that I am financially responsible to Chesapeake Weight Loss for any fees not covered by insurance. I authorize Chesapeake Weight Loss Consultants, PLLC to release any necessary personal health information to the insurance companies who will be billed. I attest that all of the information given above is correct to the best of my knowledge.

Signature date



NO SHOW, RESCHEDULE AND PAYMENT POLICIES

Dear Patients,

This is a very special practice which does NOT double book, and which schedules very long appointments to provide individual attention to each patient. Because of this Patient-Centered appointment plan, “no shows,” and patients who reschedule late, create a practice hardship, and decrease access for other patients. To help offset this significant problem, we have been forced to implement no show fees, which are listed below. Our low patient volume also means we must collect any co-payments, no show fees, self-pay charges or known patient responsibility portions of insurance payments **at the time services are rendered**. Checks which “bounce” will incur a \$35 fee. **Please sign below, indicating that you understand and agree to these policies.** Thank you for your understanding.

Beginning Visit (initial or restart medical weight loss visit) NO SHOW (failure to arrive at appointment within 10 minutes of scheduled time) or rescheduled less than one full business day (less than 24 hours, not counting weekend days) prior to appointment: \$50 (Must be paid before visit will be rescheduled.)

Office Visit NO SHOW (failure to arrive at appointment within 10 minutes of scheduled time) or rescheduled less than one full business day (less than 24 hours, not counting weekend days) prior to appointment: \$25

Aesthetic Consultation or Procedure NO SHOW or late reschedule: \$50

We understand that sometimes emergencies occur, and consideration will be given to circumstances. A single time exception may be granted to patients who notify us as soon as possible of the reason for inability to attend the appointment. However, patients with three NO SHOWS may be subject to dismissal from the practice.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____



Weight Loss Readiness and History Questionnaire

Name _____ Date _____

1. Please tell us how you found us (physician referral, friend, internet, newspaper, etc.). Why are you unhappy with your current weight? (What brought you here?)

2. List any obesity-related illnesses you have such as Diabetes, High Blood Pressure, High cholesterol, Knee arthritis, Sleep Apnea, Gout, Infertility, Migraine, Stress Urinary Incontinence or Heartburn. List any other medical problems here also. Include mental health problems.

3. If you have a weight goal in mind, about how much would you like to weigh in maintenance?

4. Are there any foods you can't or won't eat? What are they and what is the problem with them?



Weight Loss Readiness and History Questionnaire

5. Do you currently exercise? If so, describe your exercise. Are there health or other issues that limit your ability to exercise? Do you have access to a gym or indoor exercise place?

6. Do you have issues, such as very little time or money, that might make it difficult for you to see the doctor, or to buy and prepare healthy foods or exercise? Describe the issues.

7. Tell me about the other times have you tried to lose weight. Did you ever use weight loss medicines? Have you ever had anorexia, bulimia or binge eating disorder?

8. At what age did you develop a weight problem? Did any life events contribute to the weight gain? Please note your highest and lowest adult weights.



Weight Loss Readiness and History Questionnaire

9. Please list any Surgical Operations here.

10. Women, if sexually active, please list your current method(s) of contraception.

11. How much sleep do you get in an average night? Do you have difficulty falling asleep?

12. Do you work outside of your home? What is (are) your job(s)? What are your usual work hours and days? Do you do volunteer work, attend school or have other responsibilities?

13. Do you currently use tobacco? Did you previously use tobacco? Please list packs per day, the number of years smoked and quit date if applicable.



Weight Loss Readiness and History Questionnaire

14. Do you consume alcohol? What type and how much/how often do you drink?

15. Who lives in your household? Please list the people and note if they have weight or health problems. Who cooks?

16. List some of the foods you eat often:

- Breakfast-_____
- Lunch-_____
- Supper-_____
- Snacks-_____
- Drinks-_____

17. What medical problems run in the family?

- Mother-_____
- Father-_____
- Siblings-_____
- Grandparents, Aunts/Uncles, others-_____



Weight Loss Readiness and History Questionnaire

18. Please circle any of these health issues that you have had recently, or which are significant to you:

fever feeling bad all over or generally sick weakness recent weight change fatigue

rash or skin problems change in moles lumps pain in breast

headaches sinus problems vision loss hearing loss loss of balance trouble swallowing

chest pain palpitations shortness of breath swelling in legs excess need to urinate at night

cough wheezing severe snoring daytime sleepiness need to sleep propped up

abdominal pain heartburn nausea or vomiting constipation diarrhea rectal bleeding

stress incontinence (leak with sneeze, etc.) urinary urgency vaginal discharge or abnormal bleeding

joint pain muscle aches back pain gout falls trouble walking due to pain

seizures fainting memory loss numb/weak arms or legs symptoms left from stroke

anemia bleeding allergic reaction swollen lymph nodes

heat intolerance cold intolerance excess thirst/urination

anxiety hallucinations panic attacks very sad mood hopeless helpless

Explain any circled items below and add any unlisted problems or concerns:



Chesapeake Weight Loss Consultants, PLLC
A Place to Be Well

Release of Information Authorization Form

Patient Information:

Name _____,
Last/Surname *First* *Middle*

SSN _____ (May use last 4) Date of Birth _____

Provider Information: (Release information from this Provider)

Name _____ Phone _____ Fax _____

Address _____

Recipient Name: (Release the information to this Provider/Entity)

Name: Chesapeake Weight Loss Consultants, P.L.L.C. Phone: (757) 312-9444 Fax: (757) 447-3500

Address: 221 Mount Pleasant Road, Suite A; Chesapeake, VA 23322

Disclosure:

Purpose of Disclosure: Medical Weight Loss and coordination of medical care

Description and Dates of needed information _____

I understand that:

This request for Protected Health Information is not for the purpose of marketing. I may refuse to sign this authorization, and it is strictly voluntary. My treatment, enrollment, payment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization anytime in writing, but this will not affect any actions taken prior to the revocation. If the requestor is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see the disclosed information and obtain a copy for a reasonable fee if I request it. I can get a copy of this form after I sign it if I want. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV/AIDS or other sensitive information. I have read the above and authorize the disclosure of the protected health information as stated.

Chesapeake Weight Loss Consultants, PLLC

**Patient Consent for Use and Disclosure
of Protected Health Information**

I hereby give my consent for Chesapeake Weight Loss Consultants, PLLC to release protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I understand that the Notice of Privacy Practices provided by Chesapeake Weight Loss Consultants, PLLC, describes such uses and disclosures more completely and I have had the opportunity to read this notice. I have the right to review the Notice of Privacy Practices prior to signing this consent. Chesapeake Weight Loss Consultants, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Chesapeake Weight Loss Consultants, PLLC.

With this consent, Chesapeake Weight Loss Consultants, PLLC may send me a text message on my stated cell phone number, call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Chesapeake Weight Loss Consultants, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

With this consent, Chesapeake Weight Loss Consultants, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Chesapeake Weight Loss Consultants, PLLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Chesapeake Weight Loss Consultants, PLLC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Chesapeake Weight Loss Consultants, PLLC may decline to provide treatment to me.

Signature of Patient (or Legal Guardian)

Print Patient's Name

Date

(Print name of Legal Guardian, if applicable)