



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: _____