ReforMedicine SC

Medical Weight Loss Specialists

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize my ReforMedicine, SC physician(s), or advanced practice clinician (s) and/or whomever may be designated as the medical assistant(s), 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 behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction 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 medication 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 associated with remaining overweight are tendencies to have high and increasing higher 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 made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

I understand that failing to show up for an appointment I have scheduled, without calling or contacting ReforMedicine ahead of time, represents a disruption to operation of the clinic. Failure to show up ("No-Show") for a pre-appointed Follow Up Visit, or failure to cancel ***at least one full business day*** *prior to a scheduled visit will result in need to pay for the missed visit and pre-pay the next Medical Weight Loss Visit.*

I have read and fully understand this consent form and "no show" policy. I have had all of my questions answered to my complete satisfaction. I have been given all the time that I need to carefully read and understand this form.

_____ **(Initials) By my initials, I acknowledge that I have had an opportunity to review ReforMedicine S.C.'s HIPPA Policy and also acknowledge that I should request a copy, a copy will be provided to me.**

Signed,

Patient Full Name: _____ Date: _____

(Or person and relationship with authority to consent for the patient)

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POLICIES

Communication is key in providing superior care and achieving optimal results. We will do our utmost to communicate clearly and meet your expectations. In turn you will also be expected to communicate clearly with us. Please inform us if you must miss an appointment or change the care plan in some way. In order for us to provide optimal access to care and achieve the best outcomes for you, the following policies apply to the ReforMedicine Medical Weight Loss program:

_____ (Initial Here)	1. The Initial Medical Weight Loss Consult is a long appointment—in order to set aside this amount of time for a single patient, it **MUST BE PRE-PAID** a. Failure to Show Up for appointment as scheduled or cancelling with notice of **less than 1 complete business day** will result in forfeiture of Initial Medical Weight Loss Consult fees b. To reschedule, another complete Initial Medical Weight Loss Consult fee must be pre-paid
_____ (Initial Here)	2. Patients should call the clinic if an appointment must be cancelled or rescheduled **at least 1 full business day** prior to scheduled appointment.
_____ (Initial Here)	3. Failure to show up for a pre-appointed Follow Up Visit, or failure to cancel **at least one full business day** prior to a scheduled visit will result in need to pay for the missed visit AND pre-pay the next Medical Weight Loss Visit.
_____ (Initial Here)	4. If 75 or more days pass since the last medical weight loss visit, without prior arrangement between staff and patient, the patient will be considered to have dropped out of the program. a. Grace Period: If patient has not been seen in a month or two, but has not "no-showed" and less than 75 days have passed, the patient may resume progress appointments without "restart" fees b. If more than 75 but less than 180 days have passed, it is assumed the patient has been off the Eating Plan. A **pre-paid** "Re-start" fee of $200 will apply to schedule a visit to resume the weight loss program. The fee includes the office visit and new baseline lab work. (CMP and Lipids only)
_____ (Initial Here)	5. If **more than 180 days** have passed since last visit, a patient who wishes to "Re-start" in the weight loss program will be scheduled in the usual fashion for an Initial Weight Loss Welcome Visit.
_____ (Initial Here)	6. "Touch Up" or "Recharge" visits for patients who "just want help getting going again" after being away from program greater than 180 days will be pre-paid as an Initial Weight Loss Consult. $390
_____ (Initial Here)	7. No weight loss medications will be prescribed for any patient outside the context of the ReforMedicine Medical Weight Loss Program, nor outside the setting of the usual office visit. Weight loss medications are prescribed in similar fashion to any other medication that physicians prescribe. If it is determined to not be helpful in achieving results, or is detrimental to the patient, the physician has sole discretion regarding its continued use.
_____ (Initial Here)	8. From time to time, patients will request assistance with **medical issues NOT directly related to Medical Weight Loss.** If you have no primary care provider, or if seeing that provider is not possible and you wish our provider to evaluate and treat a non-weight related issue, AND time allows for evaluation during the current scheduled Medical Weight Loss appointment, the ReforMedicine, S.C. provider may agree to evaluate and recommend treatment options for such an issue AT YOUR REQUEST. Note that this will require us to generate a completely **separate office visit and office visit charge** (Level 1= $95 or Level 2=$135, depending on the problem addressed) which the patient will be responsible to pay AT THE TIME OF SERVICE as is customary of all our Fee-for-Service visits/procedures.

I have read the above policies and agree to be held accountable to these terms.

_____ _____

(Signature) **(Date)**

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Name:_____ Date of Birth: _____/_____/_____

Describing My Current Climate

I am…	Married	Never Married	Divorced	Widow/ Widower	Other:	
# of Children…	0	1	2	3	4	Other: ____
I live at home with…	Name: Age:	Name: Age:	Name: Age:	Name: Age:	Name(s): Age(s):	
The town/city I live in is…						
For a living I... (occupation)						
At this time, my exercise routine includes…	Activity:	Minutes:	Times/ week:			
My Current Stress level is…	None	Low	Medium	High		
My biggest stressor is…	Job	Relationship	Health	Other:		
My tobacco use is…	Current	Former	Never	Quitting		
My current alcohol use is...	None	Occasional	Weekly	Daily	A Problem	
My current recreational substance use is…	None	Type:	Frequency:			
My current TV/computer time per week is…	Less than 7hrs	7 to 15 hrs.	Over 15 hrs.			
I have had a problem with drug or alcohol addiction in past…	No	Yes	Which?			

My **Most Important Reasons** for wanting to *Change My Health Climate* are:

I decided to come to ReforMedicine Medical Weight Loss to help me with my weight because:
_____

My weight at age 20 was _____ lb.
My Weight one year ago was:_____ lb.
The MOST I ever weighed (non-pregnant) was_____ lb.
I began to gain weight because: _____
My **worst** food habit is_____

I am a **stress** eater	Yes	No	
I eat in the middle of the night	Yes	No	
My significant other has a weight issue	Yes	No	N/A

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time: Yes No

- *If "No" go to **Beverage** box below*
- *If "Yes" complete the following:*

During these episodes I feel I have NO CONTROL over my eating Yes No
I eat during these episodes even when I am not hungry Yes No
During these episodes I feel embarrassed by how much I ate Yes No
During these episodes I feel disgusted with myself, or guilty afterward Yes No
In the past 3 months, I have sometimes made myself vomit to try to control my weight Yes No

BEVERAGE: I **drink** the following routinely (circle all that apply):

Beverage	Number per Week
Fruit Juice	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Soda	
Diet Soda	

Typical Meals for me include: (if "none", please note that)

Breakfast	Lunch	Supper	Snacks

I have done the following **weight loss programs** before:

Program	Year	Result

I have used weight loss medication before: No Yes If yes, which? _____

I am currently using weight loss products: No Yes If yes, which? _____

The person(s) closest to me support my intentions to do this program: No Yes Unsure

Long term, I would like to maintain my weight at _____lbs. (This is my "New Climate" weight)

I would like to be at my "New Climate" weight in _____ months

If you would like to be added to our private ReforMedicine Medical Weight Loss Facebook site for additional recipes and support, please provide the e-mail address that is associated with your Facebook account:

_____

My Past Health History

My regular doctor is: _____ Town: _____

Communication in healthcare is important in order for you to receive the most comprehensive care possible.
Would you like us to communicate with your regular doctor about your care here at ReforMedicine? Y / N

At this time my overall health is (circle): Excellent Good Fair Poor

Previous or Current Health **Conditions I have had** include: (check all that apply to you)

	High Blood Pressure		Depression		Sleep Apnea		Thyroid Problems
	Diabetes		Anxiety		Asthma		Gout
	Heart Disease		PTSD		COPD		Arthritis
	Kidney Disease		Binge Eating Disorder		Acid Reflux		Fibromyalgia
	Chronic Leg Swelling		Anorexia Nervosa		Irritable Bowel/Colitis		Osteoporosis
	Bleeding Disorder		Bulimia		Fatty Liver		Urinary Incontinence
	Blood Clot		ADHD/ADD		Crohn's Disease		Polycystic Ovaries
	Anemia		Bipolar Illness		Ulcerative Colitis		Menopause
	Cancer		Alcohol/Drug abuse		Liver/Gallbladder disease		Other
	Eczema		Headache/Migraine		Stomach Ulcers		

Surgeries I have EVER had include:

Type	**Date**	**Type**	**Date**
1.		**4.**	
2.		**5.**	
3.		**6.**	

Hospitalizations, and/or Serious Injuries I have EVER had include:

Reason	Hospital Name	Date
1.		
2.		
3.		

I am **allergic** to, or do not tolerate the following medicines:

None (circle if appropriate)	**2.**
1.	**3.**

Prescription **Medications** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

Over The Counter **Medications and/or Supplements/Vitamins** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

My **Family's Health** History (circle brother or sister as appropriate; check all that apply)

Disease	**Father** Age: Living: Y N	**Mother** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N
Heart Attack/Stroke						
Diabetes						
Cancer						
Psychiatric						
Obesity						
Other						

Symptoms I am **experiencing at this time**: (check all that apply)

	Unexpected Weight Loss/Gain		Ulcers/Wounds on feet		Sadness/Depression
	Swollen Glands		Calf or leg pain while walking		Anxiety/Nervousness
	Feeling Sick		Change in bowel habits		New/unusual headaches
	Longstanding pain		Heartburn		Falling down
	Fever/Chills/Sweats		Abdominal Pain		Skin rashes
	Disturbance in Vision		Painful or trouble swallowing		Unexplained hair loss
	Eye Pain		Nausea or vomiting		Changing moles
	Hearing Loss		Yellow skin/eyes		Drinking too much
	Voice Change		Black tar/blood in stools		Low sex drive
	Fainting Spells		Constipation		Women Only
	Rapid/pounding heart		Diarrhea		Vaginal discharge
	Shortness of breath		Trouble Emptying Bladder		Pelvic Pain
	Chest Pain		Blood in urine		Breast Lumps
	Cough		Painful urination		Nipple discharge
	Blood in Sputum		Urinating too frequently		Men Only
	Wheezing		Urinary incontinence		Erectile dysfunction
	Loud Snoring		Abnormal urge to urinate		
	Stop Breathing in Sleep		Joint Swelling		
	Not well rested after full night sleep		Abnormal Bleeding/Bruising		
	Swelling in legs/ankles		Unexplained lumps or masses		

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Direct Pay Family Practice &
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Innovative, Passionate, Authentic
Transcending the standards to provide affordable, accessible, and exceptional primary care.

This form is needed for new patients only. If you are an established patient, you do not need to fill out this form.

New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL

Patient's Legal Name: _____
First **Middle** **Last**

Birthdate: _____ **Gender:** Male_____Female_____
MM/DD/YYYY

Patient's Street Address: __

_____
City **State** **Zip**

Home Phone Number: ____-____-_____ **Cell Phone Number:** ____-____-_____

Work Phone Number: ___-____-_____ **Email Address:** _____
Ext: _____ (for patient portal access)

Parent/Guardian Name (if under 18):_____

Emergency Contact Name:_____**Phone Number:**_____

Relation to Patient:_____

Do you have any allergies? Please list:_____

Preferred Pharmacy:_____

Medications/supplements

Name	Dose	Directions

_____**If you have additional medications please check here and continue the list on the back of the page.**

Please let staff know if you are on Medicare, Medicaid or Badger Care. Thank you.