

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 medical 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 over the long term.

*I understand that failing to show up for an appointment I have scheduled, without calling or contacting ReforMedicine, SC ahead of time, represents a disruption to operation of the clinic. If I should fail to call or contact ReforMedicine, SC and cancel prior to the start of the appointment, I understand NO further appointments will be scheduled for me unless I pre-pay the appointment no later than one (1) business day prior to the visit. If this should occur a second time without calling ahead to cancel or reschedule (a "no show"), **I understand that I will pay the full office visit charge for that missed appointment (\$95), in addition to pre-payment for the rescheduled 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.

Signed,

Patient Full Name: _____ Date: _____
(Or person and relationship with authority to consent for the patient)

ReforMedicine^{sc}

Direct Pay Family Practice &
Medical Weight Loss Specialists

The Medical Weight Loss program by ReforMedicine is overseen by a physician diplomate of the American Board of Obesity Medicine. As with any doctor-patient relationship, communication is key in providing superior care and achieving optimal results. Just as ReforMedicine will do its utmost to communicate clearly and meet expectations of our patients, our patients, too, will be expected to communicate clearly with us if they feel their program is not meeting their needs, must miss an appointment, or change the care plan in some way. In order for ReforMedicine to perform its role optimally, provide optimal access to care, and achieve the best outcomes for its patients, the following policies apply to the Medical Weight Loss program:

Policies:

- 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**
 - Failure to Show Up for appointment as scheduled or cancelling with less than **1 complete business days'** notice will result in forfeiture of Initial Medical Weight Loss Consult fees
 - To reschedule, another complete Initial Medical Weight Loss Consult fee must be pre-paid
- Patients are encouraged to communicate with ReforMedicine if an appointment must be cancelled or rescheduled at least 1 full business day prior to such appointment.
- Failure to show up for a pre-appointed Progress Visit, or failure to cancel at least one full business day prior to a scheduled visit will result in need to pre-pay all subsequent Medical Weight Loss/Maintenance Visits.
- 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.
- 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
- 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 call and new baseline fasting Lipid Panel and glucose level tests.
- 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 Consult.
- “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.
- No weight loss medications will be prescribed for any patient outside the context of the Medical Weight Loss Program, nor outside the setting of the usual office Initial Weight Loss Consult or Progress Check 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.

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:	Name:	Name:	Name:	Name(s):	
	Age:	Age:	Age:	Age:	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)

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

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	Mother	Brother/Sister	Brother/Sister	Brother/Sister	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)

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

