Statement of Philosophy

1. Obesity is a chronic disease, which requires a lifelong treatment.

2. Obesity is a disease process with a physiological cause, like diabetes or hypertension. It is **not** a result of "**weakness**" or **"lack of willpower"** on the part of the patient.

3. Obese individuals have a right to healthcare that is safe and fits their lifestyle. It should recognize and respect their individual, physical, social, spiritual, psychological and economic needs.

THE CENTER FOR MEDICAL WEIGHT LOSS - PATIENT DEMOGRAPHICS

CHART#

PATIENT INFORMATION:

DATE:

FULL NAME: *FIRST* *MIDDLE* *LAST* NICK NAME:

GENDER: MALE FEMALE **DATE OF BIRTH:** WHO REFERRED YOU?

RACE: AMERICAN INDIAN / ASIAN / BLACK / NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER / WHITE / DECLINED / OTHER:_____

MARITAL STATUS: SINGLE MARRIED WIDOW DIVORCED SEPARATED **SSN:**

SPOUSE'S NAME: **EMAIL:**

YOUR JOB TITLE & OCCUPATION:

YOUR EMPLOYER'S NAME: **WORK:**

YOUR SUPERVISOR'S NAME: EXT:

WHO IS YOUR PRIMARY CARE DOCTOR?

PREFERRED METHOD OF CONTACT? (circle all that apply): HOME PHONE WORK PHONE CELL PHONE EMAIL PATIENT PORTAL

MAILING ADDRESS:

CITY STATE ZIP CODE

HOME PHONE: CELL:

GUARANTOR INFORMATION: Are you under the age of 18? If yes, complete this section with a parent or guardian.

ALL MINORS MUS BE ACCOMPANIED BY AN ADULT AT EACH APPT (unless other arrangements have been previously made)

WHO IS RESPONSIBLE FOR YOUR MEDICAL BILLS? RELATIONSHIP TO YOU:

ADDRESS TO MAIL BILLS:

PHONE# FOR PERSON RESPONSIBLE FOR BILLS: CELL:

SOCIAL SECURITY NUMBER - RESPONSIBLE PARTY:

EMERGENCY CONTACT: Who can we call during office hours

NAME: RELATIONSHIP TO YOU:

ADDRESS:

HOME PHONE: CELL:

WORK PHONE: EXT: EMPLOYER:

INSURANCE INFORMATION:

If you do not have your insurance card and we cannot verify your coverage we cannot bill your insurance. Payment is due at time of service.

PRIMARY INS:

SUBSCRIBER ID# GROUP#:

WHOSE NAME IS THE POLICY IN: (Policyholder)

POLICYHOLDER'S BIRTHDAY: RELATIONSHIP TO YOU:

POLICYHOLDER'S EMPLOYER:

SECONDARY INS:

SUBSCRIBER ID# GROUP#:

WHOSE NAME IS THE POLICY IN: (Policyholder)

POLICYHOLDER'S BIRTHDAY: RELATIONSHIP TO YOU:

POLICYHOLDER'S EMPLOYER:

IF YOU HAVE ADDITIONAL INSURANCE POLICYS PLEASE LET THE RECEPTIONIST KNOW.

continued on page 2

PATIENT DEMOGRAPHICS (PG 2) CHART#

PRINT PATIENT'S FULL NAME: **DOB:**

HIPAA WAIVER: Your medical information can only be released to you unless you (the patient or POA) gives us written permission to speak with someone other than yourself. Please list below whom we have permission to speak with regarding your medical care. This can be changed at any time by only the patient and must be in writing.

1 Name of person & DOB: Relationship to you:	4 Name of person & DOB: Relationship to you:
2 Name of person & DOB: Relationship to you:	5 Name of person & DOB: Relationship to you:
3 Name of person & DOB: Relationship to you:	6 Name of person & DOB: Relationship to you:

TO ALL PATIENTS. (Must be signed by the patient, parent or legal guardian)

By signing below I (the undersigned) acknowledge it is my responsibility to notify NATALIE DOYLE, MD, PA of all changes to my account as claims will be my responsibility if denied for exceeding time limit for filing. This includes but not limited to phone #'s, addresses and insurance information. I agree by signing below I will take full responsibility for my account. I will be responsible for any unpaid balances that my insurance company does not pay. I understand it is my responsibility to see that my insurance company processes claims according to my benefits. I understand that NATALIE DOYLE MD PA is not responsible for knowing my benefits.

ASSIGNMENT OF BENEFITS: I authorize the release of medical information necessary to process claims for all services rendered to me by NATALIE DOYLE MD PA. I assign all medical and/or surgical benefits, including major medical to which I am entitled to NATALIE DOYLE MD PA. This assignment of benefits will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the originial.

SIGNATURE: DATE:

INSURANCE COMMISSIONER & HIPAA

HIPAA CONSENT TO INSURANCE COMPANY: I (the undersigned) hereby give my consent to my insurance company to provide to NATATLIE DOYLE MD PA my name, address, phone numbers and ssn listed on my insurance record. NATALIE DOYLE MD PA needs this information for payment of services rendered to me. (https://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf)

INSURANCE COMMISSIONER: I give my permission to NATALIE DOYLE MD PA to contact the insurance commissioner on my behalf if for any reason the need arises to dispute a claim(s).

SIGNATURE: DATE:

AUTHORIZATION TO RELEASE TEST RESULTS IN MY ABSENSE:

I (the undersigned) give my consent to the office of NATALIE DOYLE MD PA to release any test results ordered by this office to the following person if I am unavailable:

Name of authorized person: Relationship:

Address:

SIGNATURE:

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to NATALIE DOYLE MD PA for any services provided to me by NATALIE DOYLE MD PA 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. This assignment will reamain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the originial.

SIGNATURE: DATE:

TO ALL PATIENTS: By signing below I acknowledge that I have read this document in its entirety and the information provided by me is accurate to the best of my knowledge.

PRINT NAME:

SIGNATURE: DATE:

(If minor, Parent or gardian must sign)

WEIGHT CONTROL
EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us? (**Please circle all that apply to you)** Newsday, Daily News, Magazine, Radio, Google, mdbethin.com, liwli.com, Parent, Friend, Doctor, Drive by or Other .....

How much weight do you expect to lose? ..... Each week? ..... Each month? .....

What will happen if you don't lose that much or that fast? How will you react? .....

.....

If your weight loss slows down markedly or even completely stops for a while, will you understand the difference between fat loss and water loss? .....

What size clothes do you expect to be able to wear when you reach your goal weight?

.....

What do you expect from us (your medical counselors)? Be specific: .....

.....

Will it change your life in any way (for better or worse) when you reach your goal weight? .....

Do you expect to be doing anything you are not doing now? (describe in detail) .....

.....

Do you expect to STOP doing something you ARE DOING NOW? (describe in detail)

.....

Will you be able to handle compliments about how you look when you are of normal size? .....

Will your "new" normal weight self" pose a threat to your relationship with "significant others?" (how specifically?) .....

How will family and friends respond to the "new you?".....

Do you expect to get a better job? .....

Will you get more respect from other people?(Who specially).....

Will you feel comfortable with these altered responses from others? .....

Will you be expected to perform better at work (or at home)? .....

Will you have to be more sociable than you are now? .....

Will you have to assume any new responsibilities (please describe)? .....

.....

What will happen if some of your expectations don't come true? What might you do?

.....

What do you expect to have to do to maintain weight the same? .....

.....

Will you continue to watch your food intake? .....Exercise? .....

Continue with professional medical monitoring? .....For about how long?.....

Do you have any other expectations than those listed above?.....Specifically, what are they? Please describe them in detail .....

.....

.....

.....

Patient Name:_____ **Date:**_____

Email Address: _____

By signing this form, I understand that I may receive email communication from The Center for Medical Weight Loss from time to time related to my weight loss program. I also understand that I may elect to stop receiving such emails at any time by using the "Unsubscribe" link located at the bottom of the email communication.

HISTORY & PHYSICAL COMPLETED BY THE PATIENT

EMAIL ADDRESS:	CHART#
FULL NAME:	
ADDRESS:	

OCCUPATION:

DATE OF BIRTH:

SSN:

CELL PHONE:

HOME PHONE:

CURRENT MEDICATIONS:

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart Failure, stent, bypass, heart attack						
High Blood Pressure						
Stroke						
Cancer (List type)						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness (List type)						
Osteoporosis						
COPD						

DRUG ALLERGIES:

HOSPITALIZATION OR SURGERY:	DATE	REASON

PLEASE LIST OTHER PROVIDERS YOU SEE ON A REGULAR BASIS

HOSPITAL PREFERENCE:

WOMEN: Are you pregnant? 0 YES 0 NO — Planning pregnancy? 0 YES 0 NO

MEN: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? 0 YES 0 NO

How Often does this occur? 0 Frequently 0 Sometimes 0 Rarely

Urinary: dribbling? 0 YES 0 NO Trouble starting/stopping urine flow: 0 YES 0 NO

HABITS:

SMOKE	Packs daily?	COFFEE	Cups daily:	SEAT BELT USE:
	How long?		Other Caffeine	
	Interested in stopping?	ALCOHOL	Type:	
SLEEP	Difficulty falling asleep?		Amount:	STREET DRUG USE:
	Continully disturbances?	Diet	Salt intake	
	Snoring?		Fat intake:	
	Early morning awakening?	Do you eat out a lot?		
	Daytime drowsiness?			
	Other?			

WHEN WERE TEST / PROCEDURES LAST PERFORMED:

	DATE		DATE		DATE
BONE DENSITY		INFLUENZA VACCINE		PAP SMEAR	
COLONOSCOPY		MAMMOGRAM		TETANUS/ADACEL VACCINE	
ELECTROCARDIOGRAM		PNEUMOVAX VACCINE			
HPV (GARDASIL)		PREVNAR VACCINE			