WEIGHT MANAGEMENT MEDICAL ASSOCIATES

PATIENT INFORMATION SHEET

PATIENT INFORMATION

PLEASE COMPLETE WITH BLUE OR BLACK INK

Last Name	First Name	MI

Date of Birth	Age	Contact Number	Preferred Reminder
			☐ Phone ☐ Email

Email Address

Address	City	State	Zip Code

Social Security Number	Driver License #

Marital Status	Sex
Divorced Married Single Widow/Widower	Male Female

Employer	Occupation	Work Phone

Employer Address	City	State	Zip Code

IF INSURANCE IS CARRIED BY SOMEONE OTHER THAN THE PATIENT, PLEASE COMPLETE THIS BOX:

Last Name	First Name	MI

Date of Birth	Age	Home Phone

Address	City	State	Zip Code

Social Security Number	Driver License #	Relationship to patient

Employer	Employer Address

Work Phone	Occupation

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone number

PRIMARY INSURANCE INFORMATION

Insurance Company Name	Insurance Phone Number
Policy/Certification Number	Group/Account Number

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name	Insurance Phone Number
Policy/Certification Number	Group/Account Number

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name	Primary Care Physician Phone Number

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? (CIRCLE ONE)

- Internet
- Magazine: Plano Profile /Frisco Style
- Friend/colleague: Name: _____
- Physician/Other Medical Provider: Name: _____

I certify that the above information is true and correct to the best of my knowledge. As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

Responsible Party Signature: _____ **Date:** _____

WEIGHT MANAGEMENT MEDICAL ASSOCIATES

MEDICAL HISTORY & WEIGHT LOSS QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ AGE: _____

ALLERGIES TO MEDICATIONS: □ NONE □ YES: _____

CURRENT MEDICATIONS: □ none

Name of Medication	Dosage & Frequency

OFFICE USE:

PREVIOUS SURGERIES: □ none

Procedure	Year	Hospital	Indication

WEIGHT LOSS HISTORY:

Current Height:	Current Weight:

Goal weight:	Lowest adult weight:	Highest adult weight:

Diet Programs & OTC Supplements	**Previous (Circle one)**		**Current (Circle one)**		**Dates tried (If applicable)**	**Pounds lost (If applicable)**
Calorie restriction	Y	N	Y	N		
Food journaling/food diary	Y	N	Y	N		
Exercise	Y	N	Y	N		
Weight Watchers	Y	N	Y	N		
Jenny Craig	Y	N	Y	N		
Nutri-system	Y	N	Y	N		
Medifast	Y	N	Y	N		
Optifast	Y	N	Y	N		
South Beach	Y	N	Y	N		
Atkins	Y	N	Y	N		
Slim-Fast	Y	N	Y	N		
hCG Diet	Y	N	Y	N		
Hydroxycut	Y	N	Y	N		
Hypnosis	Y	N	Y	N		
Behavior modification	Y	N	Y	N		
Acupuncture	Y	N	Y	N		

Weight Loss Medication	**Previous (circle one)**		**Current (circle one)**		**Dates tried (if applicable)**	**Pounds lost (if applicable)**
Amphetamines	Y	N	Y	N		
Phentermine (Adipex, Fastin, Pondimin)	Y	N	Y	N		

Sibutramine (Meridia)	Y N	Y N		
Orlistat (Xenical, Alli)	Y N	Y N		
Phen-Fen	Y N	Y N		
Redux (Dexfenfluramine)	Y N	Y N		
Other (specify):	Y N	Y N		

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	SIBLINGS	CHILDREN
OBESITY								
DIABETES								
HIGH BLOOD PRESSURE								
HEART DISEASE								
CANCER								
SEIZURES								
BREATHING PROBLEMS								
KIDNEY DISEASE								
ARTHRITIS								
EARLY DEATH & CAUSE								
OTHER								

FAMILY HISTORY: INDICATE FAMILY MEMBERS HAVING ANY OF THE FOLLOWING ILLNESS

SOCIAL HISTORY:

Smoking: □ No □ Yes (# packs/day: _____; years of tobacco: _____)
Alcohol: □ No □ Yes (_____ drinks/week)
Caffeine: □ No □ Yes (tea/coffee: _____ cups/day; soda: _____ cans/day)
Exercise: □ No □ Yes (_____ times/week)

Have you ever been treated for depression? Yes No
Are you currently in treatment? Yes No
If yes, please indicate the name of your physician or therapist:
_____
Have you ever been hospitalized for mental illness? Yes No

SYSTEMS REVIEW: please circle all that apply

Constitutional:
Fatigue
Tiredness
Recent Weight Loss
Fever
Night Sweats
Abnormal Bleeding

Head and Neck:
Blurred vision
Double vision
Loss of vision
Loss of hearing
Sinus Congestion
Runny nose
Sneezing
Loss of smell
Sinus infection
Sore throat
Difficulty swallowing
Hoarseness

Respiratory:
Shortness of breath
Asthma
Wheezing
Cough
Bloody sputum
Emphysema
Pneumonia
Bronchitis
Difficulty sleeping flat
Waking at night short of breath

Gastrointestinal:
Jaundice
Hepatitis
Cirrhosis
Vomiting
Nausea
Heartburn
Abdominal Pain
Diarrhea

Men:
Discharge from penis
Loss of erection

Women:
Vaginal Discharge
Abnormal vaginal bleeding
Irregular periods
Hysterectomy
Pap exam within last year

Musculoskeletal:
Pain in joints
Muscular aches
Swelling of joints
Arthritis
Pain in hips
Pain in knees
Pain in ankles
Pain in feet
Low back pain

Skin/Breast:
Skin Cancer
Abnormal Moles
Burns
Rash
Breast mass
Nipple discharge
Mammogram with
in last year
MRSA

Neurological:
Convulsions
Fainting
Vertigo
Light headedness
Falling
Muscle weakness
Numbness
Tremors
Stroke

Lump in neck
Pain swallowing
Vertigo

Constipation
Pain with bowel movements
Blood in stool
Hemorrhoids
Changes in Stool Size
Irritable Bowel
Colitis

Herniated disk
Sciatica
Numbness in feet or legs
Abnormal Lumps or Masses

Loss of Consciousness

Cardiovascular:
Chest pain
Pain in arm/neck
Heart attack
Palpitations
Heart pounding
Stroke
Heart murmur
Pain in legs
Cold feet
Loss of pulses
Low blood pressure
Kidney stones
High blood pressure
Abnormal heart beats

Genitourinary:
Blood in urine
Frequent urination
Leakage of urination
Pain with urine
Trouble starting urine
Bladder infection

Endocrine:
Hyperthyroid
Hypothyroid
Goiter
Previous radiation
Diabetes
Adrenal gland tumor
Previous steroid use
Swollen glands

Psychological:
Depression
Nervousness
Anxiety
Suicidal thoughts
Suicide attempts
Schizophrenia
Anorexia
Bulimia
Binge eating
Counseling
Hospitalization for emotional problem
Bipolar Disorder

WEIGHT RELATED MEDICAL HISTORY (do you have or have you had any of the following illness or symptoms?)

Heart disease	Yes	No	Year of diagnosis _____
Angina	Yes	No	Year of diagnosis _____
MI (Heart attack)	Yes	No	Year of diagnosis _____
Coronary bypass surgery	Yes	No	Year of surgery: _____
Palpitations (abnormal heart beat)	Yes	No	Year of diagnosis _____
Congestive heart failure	Yes	No	Year of diagnosis _____
High blood pressure	Yes	No	Year of diagnosis _____
Elevated cholesterol	Yes	No	Year of diagnosis _____
Elevated triglycerides	Yes	No	Year of diagnosis _____
Weight loss surgery	Yes	No	Year of surgery: _____
Asthma	Yes	No	Year of diagnosis _____
Reflux	Yes	No	Year of diagnosis _____
Heartburn	Yes	No	Year of diagnosis _____
Esophagitis	Yes	No	Year of diagnosis _____
Hiatal Hernia	Yes	No	Year of diagnosis _____
PCOS (polycystic ovarian syndrome)	Yes	No	Year of diagnosis: _____
Thyroid disease	Yes	No	Year of diagnosis: _____
Shortness of breath	Yes	No	
Can you walk _____ block			
Climb _____ flight of stairs			
Sleep Apnea	Yes	No	Year of diagnosis _____
Do you use CPAP/BiPAP	Yes	No	
Sleep difficulties			
Snoring	Yes	No	
Awakening at night	Yes	No	
Daytime drowsiness	Yes	No	
Observed apnea spells	Yes	No	
Morning headaches	Yes	No	
Venous Stasis	Yes	No	
Leg or ankle edema	Yes	No	
Leg ulceration	Yes	No	

Pain of Arthritis	Yes	No	
In ankles	Yes	No	
In knees	Yes	No	
In hips	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	
Low back pain/Sciatica	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	
Diabetes	Yes	No	Year of diagnosis _____
Juvenile onset			
Gestational (pregnancy)			
Adult onset			
Diet controlled	Yes	No	
Oral medications	Yes	No	
Insulin	Yes	No	
Urinary Incontinence	Yes	No	
Leaking urine with cough	Yes	No	
Leaking urine with sneezing	Yes	No	
Leaking urine with straining	Yes	No	
Migraine	Yes	No	
Frequency _____			
Deep Venous Thrombosis	Yes	No	Year of diagnosis _____
Pulmonary embolism	Yes	No	
Abdominal wall hernia	Yes	No	
Incisional	Yes	No	
Umbilical	Yes	No	
Number of hernia repairs _____			
Have you ever had:			
Blood transfusion	Yes	No	
Hepatitis	Yes	No	
Exposed to HIV/AIDS	Yes	No	
Abused intravenous drugs	Yes	No	

PAST MEDICAL HISTORY

Please list all other medical conditions, illness or important information not previously mentioned:

_____

_____

_____

Patient signature: _____ Date: _____

The above is true, correct and complete to the best of my belief

Medical information has been reviewed by:

Physician signature: _____Date: _____

WEIGHT MANAGEMENT MEDICAL ASSOCIATES

HIPAA FORM

In our efforts to comply with the health information privacy act, HIPPA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatment with a co-worker, receptionist or secretary that regularly answers your phone calls?	Yes	No
May we leave messages on a voice mail at work?	Yes	No
May we leave messages on an answering machine at home?	Yes	No
May we leave information with a spouse or significant other?	Yes	No
Is there anyone that is not listed above that we can give information to? If so, please specify? _____	Yes	No
For any children above 18 that are still living at home, may we discuss your appointments/treatments with your parent(s) or Guardian?	Yes	No
I would like to receive regular e-mail updates and/or newsletters:	Yes	No

_____
E-mail address

You must inform us, in writing, of any changes in your directives. This record takes effect September 1, 2003 and will be kept in your file with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature:_____ Date:_____

Print Name:_____

WEIGHT MANAGEMENT MEDICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Patient name: _____

Patient/Legal Guardian Signature: _____

Date: _____

WEIGHT MANAGEMENT MEDICAL ASSOCIATES

FINANCIAL POLICY
EFFECTIVE JULY 3, 2013

Thank you for choosing Weight Management Medical Associates as one of your healthcare providers. We are dedicated to providing the best possible care and service to you. Your clear understanding of our financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide.

FEES AND PAYMENTS:
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-payments, co-insurances, and deductibles for participating insurance companies. We accept cash, personal checks (in-state only), VISA, Discover and MasterCard. There is a service charge of $25 for returned checks over and above what your financial institution charges. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

REFUNDS:
Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

INSURANCE:
We do not accept Medicare, Medicare Advantage, Medicaid, or managed care insurances that require a referral from your primary care provider. In order to address the needs of our patients without insurance and patients with coverage limitations, we charge reasonable office visit or self-pay fees. Please speak with our staff to obtain these costs.

It is the patient's responsibility to know her/his insurance coverage benefits and present his/her card at each visit. Patients who have plans that we do participate with are expected to pay their co-payments, co-insurances, deductibles, or any non-covered services at the time of their visit. Patients who are not covered by insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay at the time of service.

We bill insurance as a courtesy to you. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are expected to notify our office if your insurance coverage changes.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services they will cover; therefore we cannot guarantee payment of all claims by your insurance company. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact our **Billing Coordinator between 8:00 a.m. and 4:30 p.m., Monday through Friday at 972-303-8955, extension 101.**

COLLECTION AGENCY FEES:
Should your account become severely delinquent, the patient or guarantor agrees to pay all costs of collection including collection fees, attorney fees, and contingent fees to collection agencies in addition to the amount owed.

I, (patient name) _____ , have read and thoroughly understand Weight Management Medical Associates financial policy and my financial responsibility for all services rendered. I agree to assign insurance benefits to Weight Management Medical Associates whenever necessary. I am aware my insurance contract is between my insurance company and me, and I will be billed by my provider for any services rendered not payable.

Signature _____ Date _____

WEIGHT MANAGEMENT MEDICAL ASSOCIATES

MISCELLANEOUS OFFICE POLICY
EFFECTIVE JULY 3, 2013

MISSED APPOINTMENTS/LATE CANCELLATIONS:
We require 24-hour notice for cancelling any appointments. Please keep in mind that each missed or skipped appointment is not just time lost, but also time when other patients cannot be seen. Each missed appointment or cancelled appointment within 24 hours will be flagged. We reserve the right to charge your account a $25 fee for multiple missed or late-cancelled appointments.

We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible. We will waive the cancellation fee for this appointment as long as you do not have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those slots.

MEDICATIONS:
Our office does not participate in prior authorization requests for medications. The prior authorization process prevents our medical staff from providing you with the best possible care. In most cases, insurance companies do not pay for weight loss medications, and our providers make every attempt to prescribe weight loss medications that are reasonable. If we prescribe other therapies for weight management or associated weight-related symptoms, including but not limited to Vitamin B12, diuretics (water pills), thyroid medication, testosterone, hCG, or sleep medication, we will not process prior authorization requests for those either.

MEDICAL RECORDS:
In order to be in compliance with Texas state law and HIPAA regulations, we charge a per page charge, payable in advance, if you would like a copy of your records sent to you or another physician. This per page fee policy is available upon request. As always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there is no charge.

LAB CHARGES:
Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility.

ADVANCED HEALTHCARE PROVIDER (AHP):
A Nurse Practitioner is a registered nurse who has advanced education and clinical training in a health care specialty. Our Nurse Practitioners have national certification in their area of expertise. Dr. Garza works alongside two nurse practitioners. Nurse practitioners diagnose and manage common acute and stable chronic health problems. In addition to their traditional registered nursing skills, nurse practitioners can perform comprehensive physical examinations, order and interpret diagnostic tests, request specialty consultations, perform and prescribe therapeutic measures and furnish medications. A nurse practitioner may be involved with health promotion and disease prevention as well as patient and family education. It is your choice as a patient to decide which provider you would prefer to see, so should you have a preference please let the front desk staff know and they can schedule you with the appropriate provider.

Patient Name: _____

Patient Signature: _____

Date: _____