1513 WELLNESS & WEIGHT LOSS
3075 Tower Road Suite F Columbus, GA 31909 | 706.221.4848

Weight Loss Intake Packet

Patient Name: _____ Gender _____ D.O.B. _____

First Name Middle Initial Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Race: _____ AGE: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Employer: _____

Who to call for an emergency?

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Preferred Pharmacy: _____ **Address:** _____ **Phone** _____

How did you hear about us?

☐ Internet ☐ Social Media ☐ Patient Referral ☐ Billboard ☐ GYM

Friend/Relative Name: _____ Other: _____

MISSED APPOINTMENT POLICY

CANCELLATION OF AN APPOINTMENT

To be respectful of the medical needs of other patients, please be courteous and call the office at least 24hours in advance if you are unable to show up for an appointment. Our appointment times are in high demand, and your early cancellation will allow another patient access to timely medical care.

To cancel, please call 706-221-4848 and speak with one of our schedulers. If it is after hours, please leave a detailed message on our voicemail.

NO SHOW POLICY

A “no show” is defined as a patient who misses an appointment without cancelling in a minimum of 24 hours in advance for all provider and Mira Vita appointments. A failure to be present at the time of an appointment will be recorded in the patient charge as a “no show.” This includes arriving more than 15 minutes after the scheduled appointment time. In the event of a “no show” **1513 Wellness & Weight Loss** “may” charge the credit card on file a **$25 missed appointment fee**. This fee “may” be charged for missed appointments or appointments cancelled in let than 24 hours’ notice. We require that all patients to have a credit or debit card on file. We allow two no show appointments before considering a patient for termination from the practice. Those arriving more than 10 minutes late to their appointment may be asked to reschedule.

By signing this statement, I acknowledge that I understand and agree to abide by the terms of the Missed Appointment Policy

Signature: _____ **Date:** _____

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OUTSTANDING BALANCE & CREDIT CARD ON FILE POLICY

RETURNED CHECK POLICY

We require that all patients to have a credit or debit card on file. In the event of a check being returned for insufficient funds, we will charge the card on file for the returned check and a $25 returned check fee.

OUTSTANDING BALANCE POLICY

Any patient carrying an outstanding balance will be responsible for paying in full before seeing or being treated by a provider. Balances that reach 90-days past due will be referred to a collection agency. The collection agency will have the authority to collect the full outstanding balance due to us plus a 25% collection fee.

CREDIT CARD ON FILE POLICY

Effective 01/01/2022 you will be asked to place a credit card on file at the time you check in. The information will be held securely until your insurance/s have paid their portion and notified us of the remaining amount. At that time, the remaining balanced owed by you will be charged to your credit card and a copy of the charge will be mailed to you. This policy will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

We are under HIPPA policies, which means we are under strict rules and guidelines for protecting patients' privacy and your credit card is considered protected health information.

By signing this statement, I acknowledge, understand, and agree to abide by the terms of the medical practices Outstanding Balance and Credit Card Policy

Signature: _____ **Date:** _____

☐ **VISA** ☐ **MC** ☐ **DISCOVER** ☐ **AMEX**

Card Number: _____ **Exp Date:** _____

CCV: _____ **Billing address:** _____

I certify that I am the authorized holder and signatory of the credit card referenced above. I hereby authorize **1513 Wellness & Weight Loss** to charge the above credit card for collection of payment and charges for missed appointments within this form.

Printed Name: _____ **Date:** _____

Signature: _____

If you have questions or concerns, please ask to speak to an office manager.

CONFIDENTIALITY OF PATIENT MEDICAL RECORDS & HIPPA ACKNOWLEDGMENT

We understand that information about you, your health, and your healthcare is personal. We are committed to protecting your personal health information (PHI). We request that you sign this form acknowledging that you have been given the opportunity to read and receive a copy of our policy regarding the confidentiality of patient medical records. This acknowledgment will be filed within your medical records.

I acknowledge that I have been given the opportunity to receive and read a copy of this organizations HIPPA privacy policy.

Printed Name: _____ **Date:** _____

Signature: _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI via phone call, text or email may be provided to you and to the designated relative or friend on a voice mail at the number you provide to this office.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below on voice mail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

Patient Name: _____ **Date:** _____ / _____ / _____

Phone Number: (___) _____ **Cell phone number**: (___) _____ **Work Number**: (___) _____

Email Address: _____

Relative / Friend 1) Name: _____ **Phone:** _____

Relative / Friend 1) Name: _____ **Phone:** _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship to Patient: _____

MEDICAL HISTORY

Name: _____ Age: _____ Date of Birth: _____

Name of Primary Care Provider (PCP): _____

Current/Past Specialty Providers: _____

List your top concerns for today's visit:

_____

Allergic To:	Reaction

Medication	Dose	Reason for taking	Prescriber

Past Medical Problems:

_____

_____

_____

How does your weight affect your daily life?

_____

_____

_____

Lowest Weight: _____ When? _____

Heaviest Weight: _____ When? _____

What is your goal weight or a weight where you felt comfortable? _____

What is motivating you to lose weight? _____

What challenges do we need to overcome to reach your goal? _____

Past weight loss programs/plans: (check all that apply)

☐ I have never tried to lose weight

☐ Weight Watchers

☐ Jenny Craig/Nutrisystem

☐ South Beach/ Atkins diet

☐ Medically Supervised Treatment: (describe) _____

Have you ever taken Phentermine? Yes/ No

If yes, did you have any adverse reactions? Please explain:

_____

Activity Level

☐ Inactive- no regular physical activity/sit down job

☐ Light activity- no organized physical activity during leisure time

☐ Moderate activity- occasionally involved in weekend activities ie golf/tennis/jogging/swimming/cycling

☐ Heavy Activity- consistent lifting, climbing, heavy construction or regular Participation in jogging, swimming, or active sports at least three times a week

☐ Vigorous Activity- Participation in extensive physical exercise for at least 60 Min per session 4+ times per week

GYN History (Female's ONLY):

Date of Last Menstrual Cycle: _____ Current Birth Control: _____

Currently Breast Feeding? (circle) yes/no

Date of Last PAP: _____ Results: _____

Date of Last Mammogram: _____ Results: _____

GU History (Male's ONLY):

Date of last Prostate and Rectal exam: _____ Results: _____

Preventative Health History: Please enter dates of most recent and details if abnormal.

Preventative Test	Date	Normal	Abnormal	History of Abnormal Details
Bone Density				
Colonoscopy				

Mental Health:

Is stress a major problem for you? ☐ Yes ☐ NO

Do you feel depressed often? ☐ Yes ☐ NO

Do you panic when stressed? ☐ Yes ☐ NO

Do you have problems with your appetite? Yes No

Do you cry often? Yes No Have you ever attempted suicide? ☐ Yes ☐ NO

Have you ever thought about injuring yourself? ☐ Yes ☐ NO

Do you have difficulty sleeping? ☐ Yes ☐ No

Have you ever seen a counselor / Therapist? ☐ Yes ☐ NO

Surgical and Hospitalization History:

_____

_____

_____

Family History:

List family members with the following health conditions. Please circle if cause of death.

- ☐ Heart Disease: _____
- ☐ Heart Attack before age 50: _____
- ☐ High Blood Pressure: _____
- ☐ Diabetes: _____
- ☐ Thyroid Disorder: _____
- ☐ Mental Illness: _____
- ☐ Genetic Disorder: _____
- ☐ Breast Cancer: _____
- ☐ Ovarian Cancer: _____
- ☐ Colon Cancer: _____
- ☐ Other: _____

Tobacco Use:

- ☐ **Has never smoked tobacco**
- ☐ **Current Smoker:** Desire Quitting? ☐ Yes ☐ No ~ Year's smoking _____ Packs per day_____
- ☐ **Former Smoker**

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No if yes, how many drinks per week? _____

Do you have previous or current problems with alcohol? _____

Substance abuse:

Recreational drug use? ☐ Yes ☐ No Details _____

Prescription drug abuse? ☐ Yes ☐ No Details _____

☐ I, the undersigned, understand that I may choose to take medication for the purposes of appetite suppression and weight loss. I have been advised of the effects and side effects this medication may produce and further advised that if adverse effects are noticed I will stop taking the medication and call the clinic ASAP. Clinic hours are Monday thru Friday 8 am until 5 pm. If an adverse reaction happens outside of clinic hours, I understand that I am to go to the nearest Emergency Room. I also understand that if I become pregnant, I will stop all medications given to me and notify the physician.

☐ I do not wish to take any medication for appetite suppression or weight loss. I hereby swear that the above medical information is correct and accurate. I give my permission to any physician or physician corporation hired by Your Company to review my medical records. I also acknowledge that I have received a copy of the Notice of Privacy Practices.

Patients Name: _____

Signature: _____ Date: _____

Form Review by: _____