

Doctors Weight Loss Center of Cary

Patient Information Form  
(please print)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Driver License Number: \_\_\_\_\_

Your Primary Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name and Phone Number: \_\_\_\_\_

Have you seen Dr. Schmidt before? \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse or Parent/Guardian Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Authorization To Release Test Results

I give my consent to Doctors Weight Loss Center of Cary to release any tests ordered to the following person if I am unavailable.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## 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.

How did you hear about us? (Please circle all that apply to you) News and Observer, Cary News, Southwest Wake News, Google, Friend, Doctor, Internet, mdbethin.com, or other \_\_\_\_\_

How much weight do you expect to lose? \_\_\_\_\_  
Per week? \_\_\_\_\_ Per 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)

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

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What do you expect to have to do to maintain your weight loss?

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Will you continue to watch your food intake?

\_\_\_\_\_ Exercise? \_\_\_\_\_

Continue with professional medical monitoring?

\_\_\_\_\_ For how long? \_\_\_\_\_

Do you have any other expectations than those listed above?

Specifically, what are they? Please describe in detail.

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Can we take a before and after picture for your chart?

\_\_\_\_\_

Website/office display?

\_\_\_\_\_

Patient Name:

\_\_\_\_\_

Date:

\_\_\_\_\_



Doctors Weight Loss Center of Cary  
216 Ashville Ave. Ste. 30  
Cary, NC 27518  
Phone: 919-852-2132 Fax: 919-852-2126

Consent to Use or Disclose Information for Treatment, Payment, Health Care Operations, or  
other Uses Permitted Under HIPAA

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information "protected health information" by Doctors Weight Loss Center of Cary in order to carry out treatment, payment, or health care operations. The Patient should review our Notice of Information Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Doctors Weight Loss Center of Cary reserves the right to change the terms of its Notice of Information Practices for Protected Health Information at any time. If we do change the terms of the Notice of Information Practices, a copy of the revised notice will be mailed to you.

Patient retains the right to request that Doctors Weight Loss Center of Cary further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Doctors Weight Loss Center of Cary is not required to agree to such requested restrictions; however, if we do not agree to the Patient's requested restrictions, such restrictions are then binding on Doctors Weight Loss Center of Cary.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Doctors Weight Loss Center of Cary in writing. The revocation shall be effective except to the extent that Doctors Weight Loss Center of Cary has already taken action in reliance on the Consent.

Doctors Weight Loss Center of Cary may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative signs this consent form and then revokes consent, Doctors Weight Loss Center of Cary has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the facility is required by law to treat individuals).

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Date: \_\_\_\_\_

Time: \_\_\_\_\_ AM / PM

\_\_\_\_\_  
Signature of Patient (or authorized Representative)

\_\_\_\_\_  
Please Print Name of Patient

\_\_\_\_\_ employee initial

# Doctors Weight Loss Center of Cary

## Appointment Cancellation Policy

There will be a \$50.00 charge if you fail to cancel your scheduled appointment 24 hours in advance. Your credit card will be billed \$50.00 on the day of your visit if you fail to cancel your appointment 24 hours prior to the scheduled time. This will not be the case when rescheduling for the same week.

Payment in full is necessary prior to any treatments being rendered. The payment is non-refundable and non-transferable. In the event that you are unable to complete a pre-paid treatment regimen you could finish the treatment at a later date (up to one year from your last appointment).

Signing this agreement I accept the cancellation policy of this office.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

We will keep your credit card information on file in a secure and confidential (password protected) location.