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: _____

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)

_____

_____

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 your weight loss? _____

_____

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. _____

_____

_____

_____

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

Website/office display? _____

Patient Name: _____ Date: _____

MEDICATIONS LIST

Today's Date:_____

Patient Name: _____ DOB:_____

Please list all current medications:

Drug	*Strength*	*How Taken*

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.

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