Ideal Physician Weight Loss
Bariatric & Cosmetic Surgery

NEW PATIENT INFORMATION

Legal Name* Last:_____ First:_____ M.I._____

Preferred Name:_____ Date of Birth:_____ Marital Status:_____

Legal Sex (Please Check one)* ❒ M ❒ F Pronouns:_____

**While Ideal Physician Weight Loss recognizes a number genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

Address:_____

City:_____ State:_____ Zip code:_____

Mobile #:_____ Home #:_____ Work #:_____

Email:_____

Would you like to receive emails from Ideal Physician Weight Loss? ❒ Yes ❒ No

EMPLOYMENT INFORMATION

Employer:_____ Occupation:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Mobile:_____ Home/Work:_____

PREFERRED METHOD OF CONTACT

With my permission, this establishment may contact me and leave voice mail messages in reference to any subject that assists in carrying out patient relations, such as, but not limited to: appointment reminders and laboratory results.

Preferred method of contact: ❒ Mobile Phone ❒ Home Phone ❒ Work Phone ❒ Email

PRIMARY CARE PHYSICIAN:

Office Name:_____ Provider:_____ Phone:_____

How did you hear about our office?_____

Which program are you interested in?_____

Patient or Legal Guardian's Signature:_____ Date:_____

MEDICAL HISTORY

CURRENT MEDICATIONS

Medication	Dose	Frequency

**Please list all medications including over the counter medications, contraceptives, and supplements. If you do not have enough space please attach an additional paper with all medications.*

Medication Allergies: _____

Other Allergies: _____

SURGICAL HISTORY

Date	Surgery	Complications

Please list any recent or current medical conditions/diagnoses that we should be aware of:

_____

_____

PERSONAL & FAMILY HISTORY

If **Personal please list condition.*

Heart Disease:	❒ Personal	❒ Family	Blood Disorders:	❒ Personal	❒ Family
Kidney Disease:	❒ Personal	❒ Family	Depression:	❒ Personal	❒ Family
Lung Disease:	❒ Personal	❒ Family	Seizures:	❒ Personal	❒ Family
Diabetes:	❒ Personal	❒ Family	STD:	❒ Personal	❒ Family
Mental Disability:	❒ Personal	❒ Family	Nervous Disorder:	❒ Personal	❒ Family
Cystic Fibrosis:	❒ Personal	❒ Family	Hypertension:	❒ Personal	❒ Family
Thyroid disorder:	❒ Personal	❒ Family	Cancer:	❒ Personal	❒ Family
High Cholesterol:	❒ Personal	❒ Family	Obesity:	❒ Personal	❒ Family
Arthritis:	❒ Personal	❒ Family	Sleep apnea:	❒ Personal	❒ Family
Bipolar:	❒ Personal	❒ Family	Acid Reflux:	❒ Personal	❒ Family
Gout:	❒ Personal	❒ Family	Stroke:	❒ Personal	❒ Family
Back pain	❒ Personal	❒ Family	Palpitations:	❒ Personal	❒ Family

Please select the appropriate answer. If your answer is Yes to any of the following questions, please explain/expand when appropriate:

Are you pregnant?	❒ Yes	❒ No	_____
Are you taking birth control?	❒ Yes	❒ No	_____
Do you have a hormone condition?	❒ Yes	❒ No	_____
Do you have menopause?	❒ Yes	❒ No	_____
Do you have a pacemaker?	❒ Yes	❒ No	_____
Are you on chemotherapy or radiation?	❒ Yes	❒ No	_____
Do you take aspirin or ibuprofen often?	❒ Yes	❒ No	_____
Have you been diagnosed with diabetes?	❒ Yes	❒ No	_____
History of high blood pressure?	❒ Yes	❒ No	_____
History of chest pain?	❒ Yes	❒ No	_____
History of feet swelling?	❒ Yes	❒ No	_____

History of frequent headaches? ❒ Yes ❒ No _____

Do you have depression? ❒ Yes ❒ No _____

History of glaucoma? ❒ Yes ❒ No _____

History of bulimia or anorexia? ❒ Yes ❒ No _____

History of Phen-fen? ❒ Yes ❒ No _____

Do you snore? ❒ Yes ❒ No _____

Do you smoke? ❒ Yes ❒ No

If yes, How long?_____ How many per day?_____

Do you drink? ❒ Yes ❒ No

If yes, How many per day?_____ How many per week?_____

NUTRITIONAL EVALUATION

Maximum weight?_____

Minimum Weight?_____

Weight at 21 years old?_____

Desired weight?_____

Why is this the right time for you to lose weight and keep it off?_____

_____

Motivation scale (0 -10) _____

When did you begin gaining weight?_____

What are your main reasons for gaining weight?_____

What restaurants do you frequent?_____

How often do you frequent fast food restaurants?_____

Who shops for groceries?_____

Do you have a shopping list?_____

Who plans meals?_____

How often do you eat out?_____

Do you drink soda, caffeine?_____

Do you eat under stressful situations?_____

Is your partner overweight?_____

What are your worst food habits?_____

How many hours do you sleep at night?_____

Do you awaken at night hungry?_____

Do you use sugar substitute?_____

Food allergies?_____

Snack habits?_____

Foods you crave?_____

Foods you dislike?_____

Do you eat standing up?	❒ Yes	❒ No
Do you eat between meals?	❒ Yes	❒ No
Do you finish your meals before others?	❒ Yes	❒ No
Is quantity of food more important than quality?	❒ Yes	❒ No
Do you love high fat or high sugar foods?	❒ Yes	❒ No
Do you often do other activities while eating?	❒ Yes	❒ No
Do you eat large portions?	❒ Yes	❒ No

Typical	Breakfast	Lunch	Dinner
When?			
Where?			
What?			

DIET HISTORY:

*Please list any diets you have tried in the past and rate their effectiveness

Diet	Date	Scale (1-10)

ACTIVITY LEVEL

❒ Inactive-no regular exercise, sit down job

❒ Light-no organized physical activity during leisure time

❒ Moderate-weekends, golf, swimming, walking, jogging, etc, exercise once a week

❒ Heavy-consistently lifting, stair climbing, heavy construction, exercise many times a week

BEHAVIOR STYLE

❒ Calm, easy going

❒ Frequent impatience, restless

❒ Overwhelming ambition

❒ Never relax

Do you snack when upset or stressed?	❒ Yes	❒ No
Is it difficult for you to relax?	❒ Yes	❒ No
Is it difficult for you to be assertive?	❒ Yes	❒ No
Do you often eat to avoid thinking of upsetting things?	❒ Yes	❒ No
Do you have problems that seem insurmountable?	❒ Yes	❒ No
Are you a people pleaser?	❒ Yes	❒ No
Do you often feel sad, bored or in the dumps?	❒ Yes	❒ No
Are you actively critical of yourself?	❒ Yes	❒ No
Do you lack energy or enthusiasm?	❒ Yes	❒ No

CASH Scale: Cravings/Appetite/Satiety/Hunger

Cravings? Feeling or urge to eat when not hungry.	0—1—2—3—4—5—6—7—8—9—10 never constant
Appetite? hunger stimulated by sight, smell, sound, social	0—1—2—3—4—5—6—7—8—9—10 never constant
Satiety? Feeling of fullness acquired during eating	0—1—2—3—4—5—6—7—8—9—10 leave food seconds thirds
Hunger? Feeling of pain or ache when really hungry	0—1—2—3—4—5—6—7—8—9—10 never constant

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OFFICE & FINANCIAL POLICIES

We would like to thank you for choosing us for your medical and aesthetic needs. As one of our patients, we would like to keep you informed of the current office and financial policies for this establishment and all subsidiaries.

Please read each of the following sections carefully and initial:

INSURANCE:

This establishment does NOT participate with any insurance companies for **medical weight loss.** We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnosis codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance companies.

You may use your flexible spending account (FSA) or health savings account (HSA) but you are responsible for understanding the limits of your plan and any auditing which may occur. If you need an explanation of charges at any time, please allow 1 month of time between the time you notify us and when you need the letter.

Initial:_____

PAYMENT:

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, however, some services may require a deposit in advance. This establishment only accepts payment in the form of cash, VISA, MasterCard, American Express or Discover. We DO NOT accept checks.

Initial:_____

REFUNDS

Our establishment will provide patients with prescription medication and are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription medications for refund. **ALL SALES ARE FINAL**. Before a service is performed please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer.

Packaged food items are not refundable but we are able to exchange unopened unused packages. However we strongly discourage this practice.

Initial:_____

APPOINTMENTS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. **There is a charge of $25.00 to $100.00 for missed or late-canceled appointments.** Excessive abuse of scheduled appointments may result in discharge from the practice.

By initialing, I understand that if I continuously miss appointments or need to reschedule with less than 24 hour notice, Ideal Physician Weight Loss will require me to keep a credit card on file and authorize us to charge additional Appointment Fees that occur.

Initial:_____

APPOINTMENT TIMES:

As our patient, we value your time and want to be as transparent as possible in regards to how long you should plan on being in the office for your appointments. New patient appointments typically take an hour to an hour and a half from check-in to check-out. Follow-up appointments typically take 30 minutes to 45 minutes from check-in to check-out. Other appointment types take variable amounts of time. There are certain times of the day when appointments are in higher demand and we are a bit busier. When scheduling your appointments, please let us know if you prefer to schedule during a less busy time.

Please also be aware that the physician may at times be called into emergency procedures or surgeries, during which time we may need to reschedule appointments. We apologize in advance for any inconvenience this may cause our other patients. We will do our best to give you as much notice as possible when these situations occur.

Initial:_____

PRESCRIPTION MEDICATION:

Many of the medications that are prescribed by the medical providers of this establishment are deemed as controlled substances and must be monitored regularly in a program. All patients are required to have an appointment with a medical provider and an EKG in order to receive any prescription refills. The controlled medications will be dispensed in the office at the time of your visit.

Initial:_____

EKG

An Electrocardiogram is required for all patients who are prescribed medication. I understand that my EKG needs to be done prior to receiving any medications and I will not receive prescriptions if I choose not to have an EKG.

Initial:_____

LAB WORK

Lab work may be deemed mandatory for weight loss patients at the Doctor's discretion. I understand that my lab work needs to be completed within the first week of the physician's request. I also understand that if the results are not received by this establishment prior to my second appointment, that I will not be prescribed any additional medication.

Lab work that is drawn in the office is sent to outside laboratories and is not billed for by Ideal Physician Weight Loss. Lab work costs are not included in any of our programs and patients are responsible for all costs associated with lab work. It is the patient's responsibility to provide us with any insurance information they would like to attach for labs.

Initial:_____

GUARANTEE:

As in any procedure, treatment or program, there is no guarantee of any particular results. Results will vary based on each individual patient.

Initial:_____

ELECTRONIC RECORDING:

To ensure confidentiality and privacy, the use of any type of recording device by a patient while in our office is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentially rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits.

Initial:_____

SERVICES POLICY:

I understand that this establishment has the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain medical services and it is at the full discretion of the medical provider to determine whether I am a candidate for any services provided.

Initial:_____

GROUPON & PROMOTIONS:

At times Ideal Physician Weight Loss will offer special pricing and/or Groupon offers for specific services. As stated by Groupon: "Promotional value expires 120 days after purchase. Amount paid never expires.

Consultation required; non-candidates and other refund requests will be honored before service provided. Appointment required. **We will not honor any promotional value for the same patient twice. You may only purchase ONE Groupon.**

Limit 1 per person, may buy 1 additional as gift. Valid only for option purchased. Merchant is solely responsible to purchasers for the care and quality of the advertised goods and services."

Initial:_____

I have read, understand and agree to the office and financial policies set forth by this establishment.

PATIENT'S NAME (Please Print) _____ DATE:_____

PATIENT or LEGAL GUARDIAN'S (Signature) _____

At your request, a copy of these policies can be provided to you.

Appointments and Cancellations

Cancellation/ No Show Policy for Appointments:
When we make your appointment, we are reserving room for your particular needs. We ask that if you must change an appointment, that you give us at least a **24 hours notice** . This Courtesy makes it possible to give your reserved room to another patient who needs it. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee.

Scheduled Appointments:
We understand that delays can happen however we must try and keep the other patients and providers on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Scheduled Surgery:
Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged $100.00/Scheduled Hour. This will not be covered by your insurance company.

Saturday Appointments:
Please make sure when you schedule an appointment on a Saturday that you will be able to keep your appointment. Our office makes the effort to be staffed on a non-regular business day to accommodate our patients in need of a Saturday appointment. We ask that you respect our time and if you cannot make your confirmed appointment, give us at least a 24 hour notice or as much notice as possible so we can schedule another patient at that time. If you are running late, it would be greatly appreciate if you could call us and let us know when you will arrive. If you do not make it to your Saturday appointment or cancel/reschedule at least 24 hours in advance you will be charged a $50.00 fee.

I understand that I am responsible for the following fees, if I do not reschedule or cancel my appointment within the required time frame or if I miss an appointment.

- Weight Loss Appointments: $25.00
- All Surgical Related Appointments: $25.00
- Injectables: $25.00
- All Saturday Appointments: $50.00
- Endoscopy: $100.00
- Liposuction: $75.00/Treatment Hour
- Scheduled Surgery $100.00/Scheduled Hour

***Excessive abuse of scheduled appointments may result in discharge from the practice. We have the right to charge the credit card on file if you fail to cancel within the 24 hour time frame and/or miss an appointment with no contact to the office.**

We feel that our patients' time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for visit. Except for emergency treatment for another patient, you can expect us to be prompt . We, of course, would appreciate the same courtesy from you.

Credit Card Information

Type of Card: Card Number: Exp: CVV Code:

Print name: _____ Date:_____

Signature:_____

CONSENT - WEIGHT LOSS CONSULT

I authorize this establishment to assist me in my weight loss reduction efforts.

Potential Risks:

- Allergic reactions to prescribed medications and supplements
- Side effects of medication
- Inconvenience of lifestyle changes

I understand that some medications and supplements may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain existing disease conditions.

I do not expect my medical provider to be able to anticipate and explain all risks and potential complications. I wish to rely on the judgement of the medical providers in recommending programs that they feel are in my best interest, based on the available knowledge.

I have the opportunity to ask questions and discuss with the medical staff to my satisfaction:

- My condition
- The nature, purpose, and potential benefits of the proposed medical weight loss program(s)
- the potential risks associated with the medical weight loss program(s)
- The probability of those risks occurring
- The likelihood of success
- The possible consequences if advice is not followed and/or no weight loss programs

Injections Consent:
My medical provider may prescribe a Vitamin Shot and/or Fat Burning Shot that must be given by intramuscular (IM) injection. IM injections use a needle and syringe to deliver medication to large muscles in my body. They are usually given in the buttock, thigh, hip, or upper arm. Treatments are typically well tolerated with no serious adverse reactions.
Potential Side Effects:

- Injection Site Reaction - Temporary redness, pain or tenderness, and irritation of the skin surrounding the injection site
- Bruising - This response is temporary and may occur at the site of the injection
- Infection - Very rare complication but possible anytime an injection through the skin is performed

I have fully read and understand this consent form, and I realize that I should not sign this form if I have any questions concerning these injections. I understand the potential side effects, benefits and give my consent to receive these injections.

Initial: _____

FEMALE PATIENTS ONLY: I certify that I am not pregnant at this time, an if I do become pregnant I will immediately stop the weight loss program along with any weight loss medication, and notify this office immediately.

Initial: _____

Patient's Name (please print):_____

Patient or Legal Guardian's Signature: _____ Date:_____