LEAN MD
MEDICALLY SUPPORTED WEIGHT LOSS

130 La Casa Via, Suite 209 | Walnut Creek, CA 94598 | 925.988.9333

HEALTH QUESTIONNAIRE

FOR OFFICE USE: Today's Date Appt. Time ☐ Initial Consult ☐ Trans/Sustain ☐ Restart

First Name Last Name

Phone Email

Emergency Contact Relation to Patient Phone

Primary Care Physician Phone

HOW DID YOU FIND US? ☐ Current Patient ☐ Doctor Referral ☐ Family Member ☐ Friend ☐ Coworker
☐ Internet ☐ Advertisement ☐ Other: ______________ Referrer's Name:

CURRENT MEDICATIONS & DOSAGE

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No

SMOKING ☐ Current Smoker ☐ Former Smoker (Year Quit ______________) ☐ Never Smoked

HEALTH HISTORY: Please check off if any of the following conditions that apply to you.

____Hypertension ____Cancer ____Thyroid Disease ____Kidney Disease ____Anemia ____Substance Abuse
____High Cholesterol ____Glaucoma ____Liver Disease ____Sleep Apnea ____Eating Disorders ____Heart Attack/Heart Disease
____Diabetes ____Seizures ____Gallbladder Disease ____Migraine ____Alcoholism ____Other (list):
____Psychiatric Illness (please describe):

If female, are you trying to get pregnant? ☐ Yes ☐ No Date of last menstrual period: Birth control methods:

CURRENT SYMPTOMS: Please check off if you are experiencing any of the following conditions.

____Anxiety ____Nausea ____Abdominal Pain ____Chest Pain ____Headaches ____Vision Changes
____Depression ____Vomiting ____Irregular Heartbeat ____Dizziness ____Eye Pain ____Seizures
____Constipation ____Other (describe):

WEIGHT HISTORY Your Current Weight __________ Your Ideal Weight __________
Your Weight 1 Year Ago ________ 5 Years Ago ________ 10 Years Ago ________ Highest ________ Lowest ________

What do you feel is the cause of your weight gain?

Have you tried to lose weight in the past? ☐ Yes ☐ No

Please indicate If you have ever tried a previous weight loss regime.

____Atkins Diet ____Body For Life ____Jenny Craig ____Weight Watchers ____Low Calorie ____Low Carb
____Blood Type Diet ____Diet Medications ____Jumpstart ____Zone Diet ____Low Sugar ____Low Fat
____Low Sodium ____High Protein ____High Exercise ____Other (list):

Have you ever taken appetite-suppressing medication? ☐ Yes ☐ No

CURRENT ACTIVITY LEVEL ____Sedentary ____Light Activity ____Moderate Activity ____Very Active
Most Common Exercise / Activity How Often?

Are you currently being treated for any health concerns?

Are there any other concerns you many have that are not mentioned above?

I have answered all of the above questions to the best of my knowledge.

Patient/Guardian Name Patient/Guardian Signature Date

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Statement of Financial Obligations — 2020

Patient Name: ______________________________ Date of Birth: ______________

I agree to pay-in-full for all visits and purchases under the LeanMD Weight Loss Program in accordance with LeanMD's current billing and subscription policy as described herein.

Initial Metabolic Consultation

$250 for the initial metabolic consultation, payable at the time of the consultation, which includes:

- Complete health history and focused physical examination with LeanMD Medical Provider
- Body and metabolic composition analysis
- Electrocardiogram
- Weekly supply of prescription appetite suppressant medication for first 2 weeks
- Follow up visit with LeanMD Mentor and weigh-in
- In-office Lipo B12 injection
- One month supply of nutritional supplements (LeanProtein is also available for purchase)
- Medical Provider may require baseline labs (cholesterol panel, hemoglobin A1c, CMP and thyroid studies)
  - » Lab studies are at patient expense and may be performed at a regular physician's office or at a LeanMD laboratory partner (see price sheet below)
  - » To qualify, all labs must be performed within 6 months prior to starting the program

Flexible Schedule Programs

Elect one of the following by checking the box and initialing in the appropriate space:

❒ **LeanDebit Program –** $250 per month plus $26-$47 monthly pharmacy fee, payable in advance by ACH/auto debit (for full details see Addendum A: Payment Programs)
(Initial here if choosing this option) _______

❒ **LeanTouch Program –** $265 per month plus $26-$47 monthly pharmacy fee, payable in advance by Cash, Check or CC (for full details see Addendum A: Payment Programs)
(Initial here if choosing this option) _______

❒ **LeanToGo Program –** $320 per month (4 weekly payments of $80) plus a variable pharmacy fee every two weeks, payable by Cash, Check or CC (for full details see Addendum A: Payment Programs)
(Initial here if choosing this option) _______

All weekly programs include:

- » Weekly in-office visit and weight check
- » Body and metabolic composition analysis
- » Appetite suppressant medication dispensed weekly during the in-office visit
- » 3-4 Week in-office Lipo B-12 injection
- » LeanMD nutritional supplements available for purchase

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Monthly Weight Maintenance Program

Sustainable Loss Program – Available once weight loss goal is attained

❯ $300 membership fee covers 12 consecutive months from date of purchase:

- At Medical Provider's discretion, may require follow up laboratory studies
  - » Laboratory studies are at patient expense and may be performed at a regular physician's office or at a LeanMD laboratory partner
- Scheduled monthly telephone *or* in-office visit with LeanMD Mentor, to include:
  - » Ongoing Sustainable Loss education
  - » Virtual monitoring of body weight from home via the LeanMD Wireless e-Scale ($80 annual fee)
  - » In-office visits also include body composition analysis and Lipo B12 injection
- LeanMD nutritional supplements available for purchase
- Both billing and program to commence on the 1st day of the month following enrollment
- Rapid Rebalance includes one free week of Weight Loss Program with appetite suppressant medication, if needed
- If more than one week of Weight Loss Program is needed, you may reenroll in a Flexible Schedule Program.
  - » No restart fee will be charged to reenroll in a Flexible Schedule Program ($50 restart fee waived for current Sustainable Loss Program members only)
  - » Flexible Schedule Program fees will apply per above program guidelines, will be billed monthly, and will be prorated for mid-month starts
- **Membership in the Sustainable Loss Program may not be held, extended, prorated, credited or refunded for any reason, including but not limited to quitting the program or reenrolling in the Weight Loss Program.**

Additional Financial/Program Information

- Supplies and Supplement fees are due and payable at the time of purchase.
- If you choose to pay for any Program, Services, Supplements or Supplies by check, we may require you to submit a credit or debit card and authorize LeanMD to satisfy any outstanding balance by charging the credit or debit card if your account is not paid in full when due.
- A $35 fee will be assessed for any returned check; thereafter, check payments will no longer be accepted.
- Recurring monthly fees for the LeanDebit program are automatically charged to the (required) credit card on file on the 1st day of every month via LeanMD's secure credit card processing solution. It is your responsibility to keep your billing information current with the LeanMD Clinic, and to notify the Clinic promptly of any changes to your billing or contact information.
- Payment for all monthly programs covers four consecutive weeks, and payment for the Sustainable Loss Program covers 12 consecutive months. These payments are nonrefundable and will not be not be held, extended, prorated, credited or refunded for any reason.

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- ❒ **I have been informed that if I have an absence from the weight loss phase of the program of greater than two (2) consecutive weeks I will be expected to pay the $50 restart fee to rejoin the program.**
- ❒ **I understand that if weight loss ceases or remains static for one month, I many continue the Weight Loss Program; however, at my LeanMD Provider's discretion, I will discontinue the use of appetite suppressants.**
- ❒ **I have been informed and understand that, after completing or withdrawing from the LeanMD Weight Loss Program, the medical group and medical providers will not prescribe appetite suppressant medications for me unless I am actively enrolled as a LeanMD patient.**

Terminating the Weight Loss Program

- To terminate any monthly program you must notify us in writing by the 25th of the month, and such termination shall be effective the following month.
- Unless you notify LeanMD and expressly request that the LeanMD Wireless e-Scale transmissions be terminated, these transmissions will continue to be sent to the secure website and accessed by LeanMD for purposes of monitoring your progress, prompting you to re-enter the program or directing or recommending alternative treatments to you even after you have terminated the LeanMD Weight Loss Program. If you wish to terminate these transmissions, please notify us of this in writing.
- Direct your written LeanMD Weight Loss Program termination notification and your optional Wireless e-Scale weight transmission termination notification to your LeanMD Clinic.

Restarting the Weight Loss Program

If you are not currently enrolled in the Sustainable Loss Program and you want to restart the Weight Loss Program:

- A $50 restart fee will be charged to initiate the Weight Loss Program.
- Payment options and terms are the same as the original Weight Loss Program agreement.
- Fees do not include nutritional supplements or laboratory testing. There is an extra charge if you would like to utilize the recommended LeanMD supplements and laboratory testing.

I understand that services may or may not be reimbursed by insurance and, as a practice; LeanMD does not bill insurance companies for Weight Loss Program fees, supplies, supplements or services. I understand that LeanMD cannot guarantee reimbursement and that I am financially responsible for all charges whether or not paid by my insurance carrier. I understand that LeanMD does not and will not handle additional correspondence with insurance companies (i.e., no letters, faxes, phone calls, additional forms, etc.). LeanMD may, at its discretion, provide invoices, letters of medical necessity, and CMS forms to patients for their use. LeanMD will not alter or enter diagnosis or procedures codes unless medically justified. Obesity or Overweight will always be the primary diagnosis. I may contact my insurance company to explore reimbursement independently, and/or contact my benefits administrator to see if services are covered under a Health Spending or Flexible Spending account. I may also consult my tax advisor to see if LeanMD services qualify as deductible medical expenses. I acknowledge and agree to all of the above.

By entering into the LeanMD Weight Loss Program I also consent to the wireless transmission of my weight through the LeanMD Wireless eScale to a secure website where LeanMD can access it for purposes of monitoring my progress, treating me, prompting me to re-enter the program or directing or recommending alternative treatments, therapies, health care providers, or settings of care to me.

Patient Signature ______________________ Date ______________

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LeanMD Payment Programs

1. **NEW – LeanDebit Program.** Obtain our lowest pricing by enrolling in our new LeanDebit Program. The LeanDebit price of $250/month (plus $26-$47 monthly pharmacy fee) reflects a discount equal to $30/month compared to 2014 pricing when you place a pre-authorized credit card or checking account on file with our office.

   - Monthly billing saves you money
   - Your visits are streamlined
   - You know program costs in advance of each month

2. **LeanTouch Program.** LeanDebit isn't for you? No problem; LeanMD still offers the LeanTouch Program, an easy option where you pay monthly in advance by cash, check or credit card without automatic billing.

   - Price is $265/month plus $26-$47 monthly pharmacy fee

3. **LeanToGo Program.** If you can't or don't want to pay for each month in advance, you may enroll in the LeanToGo Program. (LeanMD no longer offers weekly billing.) With this option, LeanMD will bill you at the start of each month and allow you to make 4 equal payments during that month to pay off your balance. If you choose this option, a bill for $320.00 will be placed on your account, allowing you to pay $80.00 per visit (assuming weekly visits). In additon, a pharmacy fee will be placed on your account every two weeks, pricing will vary upon medication. Note that you will be responsible for full payment of any outstanding balance at the end of 30 days, even if you miss your weekly appointment.

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LeanMD Change of Program Agreement

Patient Name: ______________________________ Date of Birth: ______________

I am enrolling in the following LeanMD program and agree to the following fees and conditions.

› **Restarting the Weight Loss Program - $50** ________ *(Initial here if choosing this option)*

- Fee applies if you are not currently enrolled in the Sustainable Loss Program, or if you have been absent from the weight loss phase of the program of greater than four continuous weeks.

› **Flexible Schedule Program - prepaid monthly** ________ *(Initial here if choosing this option)*

- Prepaid month covers four consecutive weeks and will not be extended or credited if you fail to show for any reason.

Choose 1 option:

❒ **LeanDebit - $250/month**

» Automatically paid monthly with pre-authorized credit card or checking account

❒ **LeanTouch - $280/month**

» Paid monthly in advance by cash, check or credit card without automatic billing

❒ **LeanToGo - $320/month**

» A bill for $320.00 will be placed on your account.

» Make 4 equal payments during that month to pay off your balance

› **Sustainable Loss Program - $300 membership fee** ________ *(Initial here if choosing this option)*

- Membership fee covers 12 consecutive months from date of purchase
- Membership may not be held, extended, prorated, credited or refunded for any reason, including but not limited to quitting the program or reenrolling in the Flexible Schedule Program.

› **Termination of flexible program** ________ *(Initial here if choosing this option)*

- Membership fees will stop at the end of the four week billing cycle.

I understand that the above programs will be administered according to the terms and conditions as described in the LeanMD Statement of Financial Obligations. ________ *(Initial here)*

____

Patient Signature Date

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Payment Authorization

❒ I hereby authorize LeanMD to charge my credit/debit account monthly until such time that I officially withdraw from the Program.*

❒ I authorize LeanMD to satisfy any outstanding balance on my account by charging my credit/debit card if my account is not paid in full when due.*

Credit Card Information

❒ VISA ❒ MC ❒ AE ❒ DISC EXP. DATE ____/____

Bank Account Information

Bank Routing Number ______________________ Checking Account Number ______________________

* I hereby authorize LeanMD to charge, or to initiate transfers from, the credit card and/or bank account provided above or from any account I provide from time to time for the purpose of making the payments which I owe to LeanMD each month under the LeanDebit Program ("Program") until all of my obligations (and related fees, taxes and charges, if any) are paid under this Statement of Financial Obligations agreement (SFO), or until I officially withdraw or terminate the Program. I acknowledge that I have provided my credit card and/or checking account information to LeanMD and that I shall maintain a current credit card or checking account at all times. I understand that my obligations under this SFO agreement includes monthly payments, applicable taxes, charges and any other unpaid fees or amounts due to LeanMD. This authorization will remain in full force and effect until cancelled by LeanMD, or until LeanMD receives my written revocation. I understand that I may stop any ACH Debit (checking, savings, debit card) by notifying my financial institution at least 3 days before the scheduled date of the transfer. Cancellation or revocation of this authorization, or stopping any payment hereunder, does not affect any other payments authorized on the date of this agreement or in the future. I understand and acknowledge that the amounts debited to my account may vary each month between the amount shown above, and three times that amount, due to past unpaid amounts, applicable taxes, and other fees and charges. I understand that I have the right to receive notice in writing at least 10 days in advance of any ACH Debit (checking, savings, debit card) that will fall outside of this range. I confirm that I am authorized under the terms of the applicable agreement with my financial institution (the "Bank Agreement") to use the account I have designated for the purchase of goods and services from LeanMD. I certify that all statements made in this payment authorization are true and correct to the best of my knowledge. I understand that any failure by the applicable financial institution to pay any charge in full does not release me from any liability for obligations owing to LeanMD. I agree to comply with my Bank Agreement at all times that this authorization is in effect.

Signature ______________________ Print Name ______________________ Date ______________________

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