EZE WELLNESS & WEIGHT LOSS
Patient Registration Form

Patient Name:________________________________ Social Security Number: _____-______-______

Date of Birth: ____/_____/_____ Sex: M/F (Circle One) Married/Single/Divorced/Widow

Address: ____
(Street) (City/State/Zip)

Home Phone: (____) ______-__________ Cell Phone: (____) ______-__________

E-Mail Address: ____
Would you be interested in having communications sent to you via your e-mail address? Yes / No

Primary Care Physician: ___________________________________ Phone
(Name)

How did you hear about our practice? ____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _________________________________ Phone Number: ______________________

Relationship to Patient: (please check): ( )Self, ( ) Spouse, or ( ) Parent Date of Birth: ___-___-_____

Who to call for an emergency:

Name: ______________________________

Address: ____

Home Phone: (____) _____-________ Work Phone: (____) _____-______

Relationship: ____________

I verify that all above information is accurate. I acknowledge that I am financially responsible for payment whether or not covered by insurance. Additionally, there is a **$25 no show/ late cancellation fee for non-emergent appointment cancellations made in less than 24 hours.**

Signature: ____ Date: ___________________

Wellness & Weight Loss - MEDICAL HISTORY

Name: ____ Date of Birth: ______________________

Please select if you have had or currently have any of the following conditions:

_____ Migraines ____ Diabetes ____High Blood Pressure ____ Thyroid disorder ______ Food Allergies

____Heart Problem ____ Kidney Disease ____Seizure Disorder ____ Anemia _____ Indigestion ______Constipation

____ Eating Disorder ____ Depression ____Asthma / Lung Disease ____ Cancer _____ Sleep Disorder

Do you have any other medical conditions not listed above? ______________________________________
Are you on any special or limited diets? ___Gluten-free ___Lactose-free ____Vegan/Vegetarian ____________Other

<u>For Women</u>: Are you pregnant? ______ Are you actively trying to get pregnant? ______
Are you currently taking birth control pills? ______
Are you currently on hormone replacement therapy? _____ If Yes, specify name__________________

List any medications , vitamins or natural supplements you are currently taking

Prescription Medications	Vitamins and/or Supplements

List all of your Medication and Food Allergies. Also list what type of reaction you have:

Medication or Food Allergies	Allergic Reaction

Have you had any hospitalizations or Surgeries in past 10 years? If Yes, list below with the year:

1.______________________________ Year___________ 3.______________________________ Year___________

2. .______________________________ Year___________ 4.______________________________ Year___________

1. Does your Primary Care physician know that you are enrolling in a Medical Weight Loss program? ___Yes ___No

2 If there is a need, do you give us permission to contact your primary care physician? _____ Yes _____No

Your Primary Physician Name____ Physician Phone # ________________________

When was your last physical? (month/year) __________________________

Wellness & Weight Loss Questionnaire

Today's Date:_______________

Name ____ Date of Birth: __________________

Weight Loss Goals

What is your present weight? ____________

What is your ideal weight? ________

When do you plan to meet your weight loss goal? (month/ year) _________

Weight Management History

What is your age? _____

What was your highest weight in the past 3 years? _______________

What was your lowest weight in the past 3 years? ________________

What weight loss programs have you tried? How long where you on the program? Have you had long term success (kept weight off longer than a year)? (select below)

Program	**How Long in Program?**	**Long term success? (Y/N)**	**Are you still on this program? (Y/N)**
Weight Watchers			
Jenny Craig			
NutriSystem			
E-Diets			
Other: __________________			

What diets have you tried in the past? How long where you on this diet? Have you had long term success? (select below)

Diet	**How Long on diet?**	**Long term success? (Y/N)**	**Are you still on this diet? (Y/N)**
Atkins Diet			
South Beach Diet			

Zone Diet			
Other: ___________________			

Select the statement that best describes you (check one)

o **TYPE I** I can eat anything I want and not gain weight.
o **TYPE II** I can lose or gain weight by adjusting my activity level and eating habits.
o **TYPE III** I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

Lifestyle & Activity

What type of work do you do? (Active or Sedentary / Non-active) ____
Do you have children? __________________
Do you smoke? _____________ If yes, how often? __________
Do you drink alcohol? ___________ If yes, how often?__________
Are there other individuals in your immediate family (parents, siblings) that are obese? ___________________

How often do you exercise (check one)?
___ Rarely ____ 1-2 days per week ____ 3-5 days per week ____ 6-7 days per week

How long is your exercise activity per session? ____ None ____ <30 min ____ 30-60 min ____1 hr ___ >1hr

What Type of Exercise do you do regularly? (select all that apply)
____ Walking _____Jogging/Running _____Weight Training _____ Bicycling ____________________ Other

How would you describe your general stress level?_______ High Stress _________ Moderate ________ Low Stress
How many hours of sleep do you get per night?
______ <4 hours ______ 4-5 hours ______ 6-8 hours _______ >8 hours
How do you feel mostly throughout the day? ______ Tired & Fatigued _______ Energetic & Alert

Dietary / Nutritional History

Are you a vegetarian or vegan? _________
Approximately how may full meals do you eat a day? _______
How often do you snack between meals each day? ____ none ____ 1-2 times ____ >3 times
Do you drink coffee regularly? _____________ If yes, how many cups a day? _______
Do you drink soda regularly? ______________ If yes, how many cans/cups a day? _________
Approximately how much plain water do you drink a day (in cups): _________________

How would you describe your typical eating habits: (check one)

____ I eat a very healthy and balanced diet, consisting mostly of fresh fruit and vegetables, lean meats and plenty of water. I rarely eat “junk food” or fast food.
____ I eat a moderately healthy diet, but on occasion eat unhealthy foods . I eat fast food more than 1- 3 times a week. I drink sodas sometimes.
____ I eat a mostly poor and unhealthy diet. I eat junk food almost everyday and fast food more than 3 times a week. I drink mostly sodas or sweetened drinks more often than I do plain water.

Check all that apply:

▫ Do you often have cravings for sugary or other types of foods throughout the day?
▫ Do you struggle with eating healthy and regularly throughout the day?

How many times each day do you eat the following foods?

Starches (bread, bagel, roll, cereal, pasta, noodles, rice, potato) ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
Fruits ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
Vegetables ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
Dairy (milk, yogurt) ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
Meat, fish, poultry, eggs, cheese ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
Fats(butter, margarine, mayo, oil, salad dressing, sour cream, cream cheese) ▫Never 1-2 ▫ 3-5 ▫ 6-8 ▫9-11
Sweets (candy, cake, regular soda, juice) ▫Never ▫1-2 ▫3-5 ▫6-8 ▫9-11
What time of the day are you usually the most hungry? ____ Morning _____ Afternoon _______ Evening ____ Late Night
What meal of the day is the largest? ________ Breakfast ________ Lunch __________ Dinner
Do you have food cravings often? If so, what type? ______ Sweets ________ Salty _______ Carbs

Eze Wellness & Weight Loss- Program Selection & Contract

(Revised December 2017 – New Prices Starting January 2018)

"Get the Weight Off" Program **Monthly Plan- $190 / month (4 visits)**

This program concentrates on aggressive weight loss goals to healthily reduce your weight while learning and adapting to the new lifestyle and habit changes necessary to maintain it. (Goal loss of 20 lbs or more)

"Get the Weight Off" Plans Includes:

Detox Initiation (2 weeks)
Medical & nutritional evaluation
Transdermal Nutrient Patches (when in supply)
Energy-boosting B-12 (weekly)
Behavior Modifications Counseling
Appetite control medication (prescription) & supplements
Initial Medical Exam and Evaluation by EKG (1st visit)
Body Composition Evaluation (every visit)
Nutrition and Exercise Counseling
Weight Loss monitoring & plan modifications (weekly)

Optional **Lipotropic Injection** for additional discounted price of **$25 per shot**

"Keep the Weight Off" Program **Monthly Plan- $115 / month (2 visits)**

Typically follows completion of the "Get the Weight Off" Program once you have achieved your weight loss goal. It is designed to keep you on track for long- term success in maintaining your desired weight.

"Keep the Weight Off" Plans Includes:

Bi-weekly (twice monthly) office visits – every 2 weeks
Body Fat & Body Mass Analysis
B-12 shots (2)
Exercise & Nutritional Counseling
Individualized Behavior Modification Counseling
Prescription for appetite suppressant

Optional **Lipotropic Injection** for additional discounted price of $**25 per shot**

"Modified Weight Loss" Program **Unlimited Visits**

For those who already have their own established weight loss program and want SHOTS ONLY.

"Modified Weight Loss" Plan Includes:

Initial Weight Loss consultation- First Visit ($75 – onetime payment)

Unlimited visits per month (with selection of injection each visit)

Injections Available: **Includes Weight, Body Fat & BMI Analysis at each visit**

*Lipotropic Shot- helps burn fat, increase metabolism, control appetite and increase energy **($35 per shot)***

*B-12- vitamin to help boost energy **($25 per shot)***

Select Your Desired Plan:

"Get the Weight Off" Program _____ ($190 / month- 4 visits)

“Keep the Weight Off” Program _____ ($115 / month – 2 visits)
“Modified Weight Loss” Program _____ (by selection)

PATIENT ACKNOWLEDGEMENT/CONSENT FORM - Use & Disclosure of Protected Health Information
We are required by applicable federal and state laws to maintain the privacy of your health information according to HIPPA regulations.
ADHEARENCE TO WEIGHT LOSS PROGRAM
I understand that while on the Eze Wellness and Weight Loss Program, it is my responsibility to adhere to the recommendations given in order to achieve my weight loss goals. I acknowledge all potential risks of starting a Medical Weight Loss program and I have been cleared by my physician prior to beginning it.
PHOTOGRAPHY CONSENT FOR TREATMENT ASSESSMENT
I authorize Eze Health Center medical personnel to take photographs of me and to use them as an aid in assessment of my weight loss progress. I understand that these photographs will help document the progress of my treatment, and that any photographs taken will remain the property of the facility. I also understand that these photographs will not be utilized for any other purposes without my consent.
SERVICE & PAYMENT POLICY
I understand that FULL payment for all programs will be due at the time of service and that this payment is non-refundable. I also understand that program costs are according to established fees at the time contract is signed and that there will be no submission of fees to a Health insurance company.

By Signing, I (Patient Name- print) ____ agree to the terms of this contract as stated above.

______________________________________ ______________________________

SIGNATURE **DATE**

Financial & Health Services Policy

Welcome to *Eze Family Health Center*. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and **not** your insurance carrier, as we will not charge your insurance for the *Eze Wellness & Weight Loss Services*. **You are the sole responsible party for all charges incurred and guarantee payment**. **You will be responsible for FULL payment at the time of service**. No partial payments for services will be accepted.

In consideration of the services performed by EZE Family Health Center you agree to abide by the terms of this Financial Statement.

____

Patient Initials

PRESCRIPTION MEDICATION POLICY
Eze Family Health Center is committed to providing quality health care services for our valued patients. In keeping with this commitment, we discourage any potential issues of fraudulent use or abuse of controlled medications. It is our policy here at Eze Family Health Center, that **patients are to abide by the specific instructions given for each medication prescribed. If there is evidence that there is misuse of any of the prescribed medications, we reserve the right to discontinue refills of the medicine and issue immediate discharge from our practice.** Eze Family Health Center reserves the right to refer patients to other medical specialists if patient’s needs are beyond the scope of practice of our medical facility.

I certify that the above information I have provided on this form is correct. By signing, I understand and will follow the policy stated in this contract.

______________________________________ ____________

Signature of Patient, Parent or Guardian **Date**

____
Print Name of Patient Parent or Guardian

Protected Health Information (PHI) / HIPAA

Patient Keep Copy

Patient Name (Print) ____ Date_______________________

Due to recent implemented Federal Regulations the following public notice by EZE Family Health Center is effective as of November 1, 2011.

By Law EZE Family Health Center is required to:

Maintain the privacy of your health information.

- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.
- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.
- We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voic3e mail or answering service regarding appointments and billing questions.

There will be no information given over the phone or fax in reference to lab results. Each patient is given this information during their examination, and they are to schedule a follow-up visit to obtain lab results.

Patient with a normal pap will be notified by contacting the lab line directly. If your result is abnormal, you will be asked to contact your physician office directly.

All requests for medical records should be written and contain:

- **Social Security Number**
- **Date of Birth**
- **Insurance Carrier**
- **Mailing Address**
- **Written Signature**

In addition an advanced fee will be accessed for copy and mailing of all medical records information.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

There will be a fee of $15 dollars to complete medical forms containing 1-2 pages, and $25 for forms that contain 3 or more. Medical forms such as: school physicals, work physicals, and any other form(s) which may require the use of your medical record to complete your request.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions**: You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to suspect and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances; however, you may request a review of our denial.
4. **Amendment:** You may ask us to amend health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. You request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any question regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Privacy Officer
EZE Family Health Center
11750 Business Park Drive
Suite 103
Waldorf, MD 20601
Phone (240-419-3865

Eze Family Health Center

*****Complete then return to Receptionist*****

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Eze Family Health Center, and understand that if I have questions regarding this Notice I may contact the Privacy Officer at 11750 Business Park Lane Suite 103 Waldorf, MD 20601 (240) 419-3865.

Indicated below are names of any Person(s) to who I would like Eze Family Health Center to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation (Spouse, Child, Friend, etc.	Allowed Disclosure
1.		
2.		
3.		

__________________________________ _______________________

Patient Signature Date

_____________________________ ____________________

Signature Legal Guardian Date

Relationship to Patient_____________________________

FOR OFFICE USE ONLY
Date Received: ___________
Received By: _____________