Chesapeake Weight Loss & Aesthetics

 **Administrative Data Sheet**

**Patient Information:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last/Surname First Middle*

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Street number/Apt. City State Zip Code*

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_ Circle preferred phone #: Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, you are authorizing us to contact you by text, telephone or email about appointments and non-sensitive lab or study results. Please note any exceptions to this\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred pharmacy** name and phone number or location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next-of-Kin/ Emergency Contact information:** Relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last/Surname First*

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Street number/Apt. City State Zip Code*

**Primary Care Provider information:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name or Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Name of Policy Holder *(if other than self)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Assignment: I authorize the filing of insurance claims to any policies in force at the time of services rendered, as well as direct payment to Chesapeake Weight Loss of any amounts due. I understand that my insurance policy is a contract between me and my insurance company, and that I am financially responsible to Chesapeake Weight Loss for any fees not covered by insurance. I authorize Chesapeake Weight Loss Consultants, PLLC to release any necessary personal health information to the insurance companies who will be billed. I attest that all of the information given above is correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature date*

***Chesapeake Weight Loss and Aesthetics***

**NO SHOW, RESCHEDULE AND PAYMENT POLICIES**

Dear Patients,

This is a very special practice which does NOT double book, and which schedules very long appointments to provide individual attention to each patient. Because of this Patient-Centered appointment plan, “no shows,” and patients who reschedule late, create a practice hardship, and decrease access for other patients. To help offset this significant problem, we have been forced to implement and initial deposit system and no show fees, which are listed below. Our low patient volume also means we must collect any co-payments, no show fees, self-pay charges or known patient responsibility portions of insurance payments at the time services are rendered. Checks which “bounce” will incur a $35 fee. **Please sign below, indicating that you understand and agree to these policies.** Thank you for your understanding.

**Beginning Visit (initial medical weight loss appointment): an initial deposit of $100 is required to book the first appointment. NO SHOW (failure to arrive at appointment at least 30 minutes PRIOR to appointment time) or rescheduled less than two full business days (less than 48 hours, not counting weekend days) prior to appointment: $100 (Deposit must be re-paid before visit will be rescheduled.)**

**Office Visit NO SHOW (failure to arrive at appointment within 10 minutes of scheduled time) or rescheduled less than one full business day (less than 24 hours, not counting weekend days) prior to appointment: $35**

**Saturday Appointment NO SHOW (failure to arrive at appointment within 10 minutes of scheduled time) or rescheduled less than one full business day prior to appointment: $50**

# **Aesthetic Procedure NO SHOW or late reschedule: $50 (deposit paid to book)**

**Initial Aesthetic Consults are $35 which is applied to any purchase of goods or services and which is forfeited for a NO SHOW or late reschedule of the initial consultation.**

*We understand that sometimes emergencies occur, and consideration will be given to circumstances. A single time exception may be granted to patients who notify us as soon as possible of the reason for inability to attend the appointment. However, patients with three NO SHOWS may be subject to dismissal from the practice.*

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Chesapeake Weight Loss Consultants, PLLC

Patient Consent for Use and Disclosure
of Protected Health Information

### I hereby give my consent for Chesapeake Weight Loss Consultants, PLLC to release protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I understand that the Notice of Privacy Practices provided by Chesapeake Weight Loss Consultants, PLLC, describes such uses and disclosures more completely and I have had the opportunity to read this notice. I have the right to review the Notice of Privacy Practices prior to signing this consent. Chesapeake Weight Loss Consultants, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Chesapeake Weight Loss Consultants, PLLC.

With this consent, Chesapeake Weight Loss Consultants, PLLC may send me a text message on my stated cell phone number, call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Chesapeake Weight Loss Consultants, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked “Personal and Confidential.”

With this consent, Chesapeake Weight Loss Consultants, PLLC may e-mail to my stated email address any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

 I have the right to request that Chesapeake Weight Loss & Aesthetics restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allowChesapeake Weight Loss Consultants, PLLC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Chesapeake Weight Loss Consultants, PLLC may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient (or Legal Guardian)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Patient’s Name Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Print name of Legal Guardian, if applicable)*