WEIGHT LOSS CHART

2019
Please Fill Out Completely
*****************************************************************
Patient’s Name: ___________________________________________________________
  Last        First        Initial

Home Ph#:___________________________     Business Ph#:______________________

Cell Ph #: ____________________________    Date of Birth ________________
  (Required for medical screening)

Home Address:  __________________________________________________________
  Street

City  _____________________________  State  _____________________________  Zip

E-mail Address:  __________________________

Nearest Relative Name: _____________________________________________________

Address:  ___________________________________________     Ph #: _________________________

How did you hear about us?
_____ Yellow Pages  _____ Drive-by
_____ Mail  _____ Newspaper Ad
_____ Office Sign
_____ Website

Have you used a professional weight loss/management program in the past? If yes, which one(s)?

Jenny Craig _____  Weight Watchers____  Physician’s Weight Loss____
Other Doctor___  Other_______________________________________________________

Comments: (Did you lose weight? Did you receive counseling? Were you on prescription medication? If so, provide the name.

_______________________________________________________________________
Please ask about our referral program.
# Medical & Family History

(Please check the ones that apply)

<table>
<thead>
<tr>
<th>Health Care Problem</th>
<th>Self</th>
<th>Father</th>
<th>Mother</th>
<th>Father's Parents</th>
<th>Mother's Parents</th>
<th>Siblings</th>
<th>Children</th>
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<tbody>
<tr>
<td>Cancer (type or location)</td>
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<td>Lung Disease</td>
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<td>*Diabetes (See page 4)</td>
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<td>Epilepsy/Convulsions</td>
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<td>Osteoporosis</td>
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<td>Mental Illness</td>
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*Diabetics must comply with monitoring. See page 4 for details.

## Current Medical History

Please print // list your current medication(s) and reason(s):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

(Required for medical and prescription medication screening)

Are you allergic to any medications? _____ Yes _____ No

Please List:

________________________________________________________________________________

## Hospitalization or Surgery

Write in the reason and the date

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
**PAST MEDICAL HISTORY** – Check all that apply (For immunizations, place a √ and dates (year))

| ☐ Diphtheria | ☐ Depression | ☐ Gall Bladder Disease |
| ☐ Hepatitis | ☐ Nervousness | ☐ Bowel Irregularity |
| ☐ Measles | ☐ Dizziness/fainting | ☐ Incontinence |
| ☐ Mumps | ☐ Heart Palpitations | ☐ Prostate Disease |
| ☐ Pneumonia | ☐ Heart Murmur | ☐ Sexual/Menstrual Dysfunction |
| ☐ Polio | ☐ Shortness of Breath | ☐ Breast Disease |
| ☐ Rheumatic Fever | ☐ Chest Pain | ☐ Venereal Disease |
| ☐ Rubella | ☐ Peripheral Vascular Disease | ☐ Arthritis |
| ☐ Tetanus | ☐ Allergies/Hay Fever | ☐ Gout |
| ☐ Other Immunizations | ☐ Asthma | ☐ Abnormal PAP/Mammogram |
| ☐ Scarlet Fever | ☐ Bronchitis | ☐ Pregnancies (Number) |
| ☐ Chronic Rashes | ☐ Tuberculosis (TB) | ☐ Live Births (Number) |
| ☐ Mononucleosis | ☐ Abnormal TB skin test | ☐ |
| ☐ Anemia | ☐ Stomach Ulcer | ☐ |
| ☐ Frequent Infections | ☐ GI Disorder | ☐ |
| ☐ Headache | ☐ Lactose Intolerance | ☐ |

Do you want your primary physician to be informed of your progress during the course of this program?   ___ Yes   ___ No

Name___________________________________________   Ph#: __________________

**Lifestyle**

Do you smoke or use tobacco products?   ___ Yes   ___ No
How much do you use on a daily basis?
Number of cigarettes____   Number of Cigars ____   Amount of chewing tobacco____

Do you drink alcohol?   ___ Yes   ___ No
How many glasses do you consume on a weekly basis? ________

Do you currently exercise?   ___ Yes   ___ No
If so, what kind of exercise and how often?________________________
Patient Weight Goals

How much total weight do you want to lose? _____ lbs          Present weight _____ lbs
What is your height? ______

How fast? (Check one)

____ 5 to 8 pounds per month
____ 10 to 12 pounds per month
____ 15 to 20 pounds per month

What is your present dress/pant/suit size? _____  What size would you like to wear? _____

Financial/Refund Policies and Patient Responsibility:

• There are no refunds for services rendered for our weight management fees. All applicable payments must be made in advance of service. We offer no payment plans.

• Health Insurance is not accepted by Doctor’s Weight Loss Centers, Inc.

• Individuals with flexible spending accounts will receive appropriate documentation to receive reimbursement from their employer. Allow 5-7 working days for preparation.

• Patient will pay for follow-up lab work at their own expense every 4 months to remain on prescription medication and provide current EKG and physical upon request.

I attest that all the above information is true. I have also read and understand the refund / financial policies and patient responsibility mandated by Dr. Heron and the Doctor’s Weight Loss Center’s staff.

Patient Signature:__________________________________     Date:_______________

FOR PATIENT’S WITH DIABETES:

If you ARE a *diabetic and take prescription medication for your diabetes, you MUST visit with your primary care physician for close monitoring of your medication and sugar levels while on our weight loss program. A signed agreement from your physician must be provided for your file BEFORE you are accepted on our weight loss program. Failure to do so will expel you from our program.

Patient Signature: _________________________________     Date: ________________
Cancellation Policy

Dear Patient:

Quite a few patients want to be seen. We know you want to be seen in a timely manner. In order to accomplish this, I schedule the appropriate number of patients to be seen in a set time. That is my responsibility to you. I ask that, in return, you respect my time as well as other patients.

If you cannot keep your appointment, CALL TO CANCEL, 24 hours before your scheduled appointment so that we may schedule another patient for that time. DO NOT send cancellations through email nor to my cell phone. Please call the office where your appointment is scheduled. If we are closed, please leave a message. All business must function with this understanding.

ALEXANDRIA: 703-549-2626

A $50 charge will be assessed for ALL NO SHOWS (un-cancelled appointments). Fees for un-cancelled appointments will be annotated to your individual invoice with payment expected before your consultation on your next visit. Please honor this policy to avoid unnecessary charges.

I have read the above and I understand that I will be charged $50 if I fail to cancel my appointments. I also understand that this charge is in addition to any payments.

Signed ___________________________________________ Date ______________________

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice.

"Individually identifiable health information" is information, including demographic data, that relates to:
• the individual’s past, present or future physical or mental health or condition,
• the provision of health care to the individual, or
• the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

If you feel your individuals rights, including the right to complain or if you believe your privacy rights have been violated, you may contact the HHS directly.

Patient Name_________________________________ Relationship to Patient:______________

Print

Signature:___________________________________ Date:____________________________
B-12 Shot Authorization

Because your carbohydrate intake will decrease while you lose weight, your energy level may decrease as well. Replenish your body’s energy naturally with Vitamin B-12 injections. This important vitamin also helps boost your energy, metabolize fat and boost calcium absorption.

Please Fill Out Completely
*******************************************************************************

Patient’s Name: __________________________________________________________
Date of Birth: __________________________

Have you ever received a Vitamin B12 shot before?       Yes___          No___
If you answered yes, did you have any adverse reaction? Please explain:
________________________________________________________________________

Allergies to Medication   (  ) Yes    (  ) No
If yes, which ones?   _______________________________________________________

I have read the above and the benefits and risk of receiving vitamin B12 has been explained to me. In addition, I have been able to ask questions that were answered to my satisfaction. I hereby hold Dr. Heron’s office harmless if I should have a reaction to the B12 shot. In conclusion, I hereby authorize Dr. Heron’s office to give me this shot.

Patient’s Signature ___________________________________________ Date

Staff ___________________________________________ Date
Marketing Authorization and Use of Photographs

According to federal law we must ask for your permission to send to you via email, text, social media or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts, Open House invitations).

Our office DOES NOT SELL or SHARE our patient’s names or information.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing or email. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I DO ________ I DO NOT ____________ Please select one

Authorize Heron Med Spa services or promotions the practice offers. You may choose email, cell phone or both.

I DO ________ I DO NOT ____________ Please select one

Authorize Heron Med Spa to use my photographs.

______________________________________________________________
Patient Signature                                          Date

______________________________________________________________
Email Address Please Print

______________________________________________________________
Cell Phone Number

Weight Intake Form 2019