Buckeye Physical Medicine and Rehab, LLC.
Weight Loss Patient Intake

GENERAL INFORMATION

Name: ____ (Age) _______ Gender: M F

Home Address: ____ Home Phone: ______________________________

City, State, Zip: ____ Work Phone:______________________________

Email Address: ____ Cell Phone: ______________________________

Birth Date: ______ / ______ / _______ Social Security #: ________ - ______ - _________ Marital Status: S M D W

Drivers License Number and State issued ________________________ State _____________

As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders? [ ] Yes [ ] No If yes, who is your cell phone provider? ____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor __________________________________ Date ___________

HEALTH HISTORY

Current Height____________ Current Weight___________ Max Lifetime Weight ___________ Desired Weight____________

In what time frame would you like to be at your desired weight? ____

What is the main reason for your decision to lose weight? ____

When did you begin gaining excess weight? ____

Previous diets you have followed, including dates, and any results you received from weight loss attempts. ___________________

____

Is your spouse, fiancée or partner overweight? _____________ Do you awaken hungry during the night? ____________________

How often do you eat out? ______________________ How often do you eat fast food? __________________________________

Do you wake up hungry in the morning? _____________ What time of day are you most hungry? _________________________

On average, how many hours of sleep do you get per night? ____

Who is your primary care physician? (doctor and/or practice) ____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting
- ❑ Eczem

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other________________

____

____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain ____

Please list any medications you are currently taking (Be sure to include dosage and frequency) ____

____

Please list any surgeries and/or hospitalizations you have had (type & date) ____

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If you are male, when was your last prostate exam? __________________________ Normal prostate results? ___________________________

Please list any supplements you are currently taking (vitamins, minerals, herbs)____

Are you currently on any blood thinners – (aspirin regimen included)? ☐ Yes ☐ No List Type ____________________________________

Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.

Please CHECK if you have any of the following: ☐ Type 2 Diabetes ☐ Sleep Apnea ☐ High Cholesterol ☐ A pacemaker

☐ Suffer from blood clots ☐ Local or systemic infection ☐ Allergies (please list) ____

☐ Atria Fibulation ☐ Uncontrolled Hypertension ☐ Glaucoma ☐ Rapid Heartbeat ☐ Severe Depression ☐ Uncontrolled clotting disorder

☐ Renal Disease ☐Pregnant/Breast Feeding ☐ History of Stroke ☐ Hyperthyroid ☐ History of Drug/Alcohol Abuse

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease ___________________ ☐ Diabetes ___________________ ☐ Stroke ___________________

☐ Cancer ___________________ ☐ Arthritis ___________________ ☐ Other ___________________

Do you exercise?: ☐ Yes ☐ No How often?: 1X 2X 3X 4X 5X per week Other: _____________________________________

Which activities: ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other _____________

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine___________ cups/day Alcohol ___________ drinks/week Energy Drinks___________ cups/day Cigarettes___________ packs/day

I hereby certify that the previous questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature____ Date___________________

Doctor Reviewed Signature ____ Date___________________

Doctor Updated Signature ____ Date___________________

AUTHORIZATION OF CARE

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services) ____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Name Printed	Date	Patient's signature	Date

Minors Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

I hereby authorize Buckeye Physical Medicine and Rehab LLC to administer care as deemed necessary to my child, a minor under the age of 18 years old.

EMERGENCY CONTACT

Name_______________________________________ Work Phone__________________________________

Relationship ________________________________ Home Phone__________________________________

Cell Phone__________________________________

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT
(CONSENT TO USE PHI)

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Buckeye Physical Medicine and Rehab, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient’s Full Name	Time of Day
Witness Signature	Date

WLP Consent Form

I, ____, authorize Buckeye Physical Medicine and Rehab, LLC and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques and may involve the use of appetite suppressant medications. Other treatment options may include a low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks and hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Please note: Signing this form in no way obligates you to participate in the program.

Patient's Signature ____**Date**______________________

Financial Consent Policy Form

Thank you for selecting Buckeye Physical Medicine and Rehab, LLC for your health care needs.

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I, ___________________________, agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I understand that all products are non-refundable and cannot be returned to Buckeye Physical Medicine and Rehab.

I have read and understand all of the above and have agreed to these statements.

All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient Signature ____ **Date** _________________________