



Thank You for choosing us for your weight loss journey!

Our weight loss Program is outlined below

- You will be seen every 2 weeks for 4 months then monthly until you reach your goal.
- A body Composition scan will be done at each visit. This is very important to make sure that you are losing weight and your body composition is changing appropriately.
- Weight loss medications that we use include the following. Please check with your insurance if they cover any of the following medications:
Phentermine Topamax Contrave Saxenda Belviq
- Please follow the check list provided in you packet.
- We need current copies of your labs by your second visit. Otherwise they will be ordered by us. This is to screen for prediabetes, fatty liver, atherosclerosis etc.
- The program emphasizes lifestyle change and healthy weight loss. We do not make guarantees.
- We need an accurate list of any medications you are taking.
- We recommend Dr Katz at eatsanely.com for counselling regarding psychological association with food.
- We recommend Beth@rawhealth.life as a health coach
- Consider Planet fitness, Best fitness, Orange theory and Healthtrax for physical activity.

Patient Information Form

Please print clearly and fill in all fields.

Name _____ Date of Birth ____ / ____ / ____

Social Security Number ____ / ____ / ____ Primary Care Physician _____

Gender: Male Female

Marital Status: Married Single Divorced Widowed Legally Separated Other

Mailing Address:

Street _____ City _____ State _____ Zip Code _____

Billing Address: (If different from Mailing Address)

Street _____ City _____ State _____ Zip Code _____

E-Mail _____ Home Phone _____ Cell Phone _____

Ethnic Group: American Indian Asian or Pacific Islander Black Hispanic White Unknown

Primary Language(s) spoken at home _____ Do you need an interpreter? _____

Employer _____ Address _____

Work Phone _____ Retired Unemployed Disabled Student

Emergency Contact Information

Contact Name _____ Relationship _____ Phone _____

Contact Name _____ Relationship _____ Phone _____

Insurance Information

Primary Insurance _____ ID Number _____

Name of Subscriber _____ Relationship _____ Date of Birth _____

Secondary Insurance _____ ID Number _____

Name of Subscriber _____ Relationship _____ Date of Birth _____

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other insurance Company benefits be made on my behalf for any services furnished to me by its physicians or employees. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me, to release to my insurance company, the Social Security Administration and Health Care Company claim, as applicable. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.)

Signature

Date

New Patient Questionnaire

Name _____ Date of Birth _____ Date _____

Do you have any current concerns you would like addressed?

MEDICATIONS: (Include prescription medications, over the counter medications, vitamins, herbs and supplements)

Drug Name	Dose & Frequency	Drug Name	Dose & Frequency

ALLERGIES: (List all allergies to medications, x-ray dye, or other substances)

	Reaction: _____
	Reaction: _____
	Reaction: _____
	Reaction: _____
	Reaction: _____

MEDICAL HISTORY

Please check next to any problems with or are presently experiencing any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Anemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Fractures/broken bones	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Gout	

Use this space if you wish to explain in detail:

OPERATIONS/HOSPITALIZATIONS: (Females: If you have had a hysterectomy please include information here)

Reason	Date

HEALTH MAINTENANCE

Please check if you have had any of the following tests and write the date it was done:

Pap Smear	Date:	Cholesterol Check	Date:
Mammogram	Date:	Stool Check for Blood (FOBT)	Date:
Breast Exam	Date:	Colonoscopy	Date:
Bone Density	Date:	Prostate Exam	Date:
Diabetic A1C	Date:	Flu Shot	Date:
Diabetic Urine Micro Albumin	Date:	Pneumonia Shot	Date:
Diabetic Eye Exam	Date:	Tdap Vaccine	Date:
Glaucoma Screening	Date:	Shingles Vaccine	Date:

FAMILY HISTORY

Please check if your family (parents, grandparents, siblings, or children) has ever had one of the following:

Cancer	Mental Disease (Depression/Anxiety)
Heart Disease	Memory Problems/Alzheimer's Disease
Hypertension	Osteoporosis/Broken Bones
Diabetes	Other
Stroke	

LIST FAMILY MEMBERS, PARENTS, SIBLINGS, AND CHILDREN

Father:	L or D	Age:	Illness:
Mother:	L or D	Age:	Illness:
Siblings: Male or Female:	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
Number of Children:			

SOCIAL HISTORY

Marital Status Please Check: Married Single Divorced Separated Widowed

Highest Grade Level Completed: _____ Occupation: _____

Do you currently live alone? Y or N Do you have any concerns about your living situation? _____

Do you smoke or have you ever smoked cigarettes or cigars? (including chewing tobacco) Y or N

#packs/day _____ #of years _____ Quit-When? _____

Do you currently or have you ever used Alcohol? Y or N

#per day _____ #per week _____ When did you stop? _____

Do you currently or have you ever used recreational or street drugs? "i.e. marijuana or cocaine" Y or N

When did you stop? _____

Patient Signature _____ Date _____

PHQ9-Patient Health Questionnaire

(NPV, CPE an H/O Depression)

Patient Name _____ Date of Birth _____ Date _____

Over the last 2 weeks how often have you been bothered by any of the following problems?
Circle the number to the right for your answer.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking slowly that other people have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each line:	+	+	+	

= Total Score _____

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not At All Somewhat Very Extremely



ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name: _____

Date of Birth: _____

It is a possibility that your health insurance may not cover the service provided for you today. All insurance companies have different guidelines that need to be met to cover charges.

The purpose of this form is to help you make an informed decision about whether you want to receive these services, knowing that you may be responsible for any charges not covered by your insurance.

SERVICES THAT MAY NOT BE COVERED:

- | | |
|-------------------------------|-------------|
| (a) Body Composition Analyzer | \$50/scan. |
| (b) Supplements | Prices Vary |
| (c) Vitamin B12 | \$25/month |

Date _____

Signature _____

Personal Primary Care & Weight Management

Payment Policy

Thank you for choosing us as your primary care/specialty provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments, deductibles and any balance due must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days the balance will automatically be billed to you.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of responsible party _____ Date _____

Personal Primary Care & Weight Management

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

(To be filed in Patient's Medical Record)

This acknowledges receipt of Personal Primary Care & Weight Management's Notice of Privacy Practices, including my rights under the privacy regulations, 45C.F.R., Parts 160 and 164, issued pursuant to the Health Insurance Portability and Accountability Act.

Signature

Date

Please Print Name

Internal Use only

If patient/patient's representative refuses to sign acknowledgement, document date and time notice was presented and sign below.

Presented on _____

By _____



299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Late, Cancellation and No Show Appointment Patient Letter

Dear Patient:

We sincerely appreciate that you have chosen a provider with Personal Primary Care & Weight Management to participate in providing you with comprehensive and quality healthcare. We ask for your help in accomplishing this goal for all of our patients by following the practice guidelines below:

1. Cancellation for Provider Appointment

Personal Primary Care & Weight Management providers require a minimum of 24 hours in advance to cancel an appointment.

2. Late Arrival for Provider Appointments

We understand that delays can happen, arriving late may prevent you from being seen by the physician, when you arrive it may be determined by the physician if he/she can fit you into the schedule at that time, or you may be requested to reschedule.

3. No Show for Provider Appointments

A "no show" for appointments is when you do not call to cancel or reschedule your appointment a minimum of 24 hours prior to your appointment and/or if you just do not show for the scheduled appointment.

Patients that arrive late and do not call to cancel or do not show up for their appointments cause disruption in patient care and satisfaction for all patients. If you are habitually late to your appointments or "no show" for your appointment 2 times in a 12 month period causing a disruption in all patients care, you may be terminated from this practice. There will be a \$25.00 charge for "no show" to your appointment which has to be paid in full before future appointments.

Sincerely,
Personal Primary Care & Weight Management

By signing this letter I understand and agree to the terms stated herein:

Patient Signature: _____ Date: _____



299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Consent Form

I, _____ give permission to Personal Primary Care & Weight Management to allow the undersigned to speak with my Primary Care Provider/Medical Staff in regards to my medical history, care, and treatment. This consent is valid until I request in writing that it be voided. This is in compliance with the HIPAA (Health Insurance Portability and Accountability Act) to protect patient's confidentiality of medical information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I, _____ give permission to Personal Primary Care & Weight Management to allow the undersigned to pick up prescriptions and other paperwork from the office if the need arises. Photo ID will be required for prescription pick up.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature

Date of Birth

Date

Witness

Date



299 Carew Street, Suite 234
 Springfield, MA 01104
 Tel. (413) 787-2575
 Fax (855) 569-3033

Name _____

Height _____ Weight _____ Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

BANG		
BMI more than 35kg/m ² ?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

Program for Weight Management

INFORMED CONSENT FOR TREATMENT

A. GENERAL DESCRIPTION

The program for weight management utilizes physician-directed weight control programs. These programs have been developed to treat obesity in adult patients, particularly when such therapy can assist in the management of weight-related health problems. The program for weight management has determined that for most obese patients who seek professional help, the most reliable way to achieve significant weight loss is to use a nutritionally adequate, medically supervised low calorie diet with exercise. This may be combined with prescription medicine and/or surgery to achieve optimal and durable weight loss.

I understand that the program for weight management offers no medical care other than weight reduction and may periodically provide regular reports to my personal physician. I understand that I cannot remain on a medically supervised low-calorie diet indefinitely. Accordingly, I also understand that the program for weight management requires a careful, gradual transition from a medically supervised low calorie diet to a weight-maintenance lifestyle. I recognize that it is pointless to expect permanent weight loss from involvement in the program in the absence of active participation in a strong weight-maintenance program in association with an appropriate exercise program.

It is understood that I will undergo a medical history, physical examination, electrocardiogram (as recommended), laboratory blood tests and other measurements to determine my suitability for the program and to plan individualized treatment and maintenance programs. I will be seen by a physician regularly as indicated, undergo laboratory testing at regular intervals and attend a unique series of behavioral, nutritional and counseling sessions on a weekly basis. I understand that attendance at these follow-up visits is important to ensure safe weight loss in a medically supervised environment and that the behavioral program continues after the weight loss goal has been achieved.

I understand that I may participate in one of four treatment plans, depending on what is appropriate for me. These are:

1. Calorie-Controlled Diet
2. Prescription Medicine and Calorie Controlled Diet
3. Liquid Formula Diet
4. Food and Liquid Formula Diet

B. BENEFITS

The potential medical benefits of these forms of treatment have been explained to me. These may include decreased blood pressure, lowered blood sugar, lowered blood cholesterol and triglycerides, lowered risk of heart disease and stroke, as well as enhanced psychological wellbeing. The decreased risk of developing obesity-related disease may increase my longtime survival. However, I understand that no guarantees have been made to me concerning the results of any of these forms of treatment.

C. ASSOCIATED SIDE EFFECTS AND RISKS

The program for weight management has been designed to minimize the undesirable side effects associated with therapeutic weight loss. However, the programs for weight management cannot guarantee that side effects will never occur. Thus, it has been explained to me that weight reduction

bowel changes, and increased uric acid level in the blood. In rare cases, rapid weight loss subjects a nerve in the leg to unusual pressure leading to numbness or loss of muscle power. This is usually temporary and I can prevent it by avoiding activities that compress the nerves, such as prolonged crossing of the legs. Other rare effects are the appearance of previously undetected gallstones or gout. In addition, it is conceivable that other side effects could occur which have not been observed to this date.

DRUG RISKS

I understand that the drugs used for assisting weight reduction may cause me to have a wide variety of symptoms, including dry mouth, anxiety, nervousness, insomnia, drowsiness, fatigue, depression, tremor, lightheadedness, dizziness, rapid heartbeat, irregular heart rhythm, increased blood pressure, low sodium level in the blood, altered sexual function, and stomach complaints such as nausea, pain, loss of appetite, and diarrhea. I also understand that a small number of patients have become depressed and manic disorders occurred in others, but the relationship to the drugs is not clear. Obesity drugs are classified as having addiction or abuse potential, but the risk is thought to be very small. If I take phentermine on a long-term basis, I may feel tired for several days after its discontinuation.

I understand that with administration of any drug, there is the possibility of an allergic reaction that may cause skin rash, difficulty breathing, collapse, or even death. Such reactions are very rare with all the drugs used in this treatment program.

The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects. Some reports have suggested a relationship between programmed diets and sudden death, probably due to irregularities of the heart. I understand that participation in this weight reduction program may entail an extremely low risk of fatal heart irregularities. Regular checkups, including EKG monitoring as indicated, are designed to keep the risk at a minimum.

I understand that withdrawal from normal eating can be emotionally stressful, and an individual's reaction to this form of therapy for obesity cannot be predicted. It is possible that I may develop symptoms of depression, agitation, or excessive anxiety.

If I am taking any medications for any other reasons besides weight loss, i.e., for depression, migraines, or colds/allergies, I understand that weight loss may affect the dosage or need for the medication, and that my personal physician may want to adjust my medication and associated treatments.

D. PROGRAM PROCEDURES

1. I understand that it is essential that I consume no less than the total amount of formula diet and/or food prescribed, as well as the recommended amount of fluids, and that failure to consume the total amount may be harmful to my health. Moreover, I understand that if I interrupt the prescribed low calorie formula diet program by abruptly consuming a meal of regular foods, I may develop some gastrointestinal distress, bloating, diarrhea, and/or constipation.
2. I understand that successful weight loss includes not only the diet plan I have chosen but also participation in a regular, structured exercise program. I must obtain written clearance from my personal physician before participating in an exercise program.
3. I understand that there is a staff member on call and available by telephone 24 hours a days with physician backup. Should I have any problems I feel are associated with the program I will call the office immediately.
4. My general medical problems will continue to be treated by my personal physician. My personal

5. If at any time the program physician feels that it is in my best interest, he/she may discontinue my participation in the program. I understand that it is my responsibility to be present at all office sessions. My failure to attend any session(s) will be cause for the supervising physician to reevaluate my continued participation. Since such absences may be detrimental to my health, I may be discharged from the program from weight management.
6. All medical, surgical, psychiatric or hospital expenses incurred by me as part of, or resulting from, any participation in the program, will be my sole responsibility. Neither my physician, staff, nor the program for weight management will assume responsibility for any of my medical expenses at any time.
7. FOR PATIENTS WHO MAY BE PREGNANT OR CONSIDERING PREGNANCY: I understand that caloric restriction may have damaging effects on a fetus. To the best of my knowledge, I am not pregnant and have been made aware that I should not become pregnant while under treatment in the program for weight management. If I become pregnant or suspect that I am pregnant, I will notify the program physician immediately and will also notify my personal physician. If I become pregnant or suspect that I am pregnant, I will begin a regular diet until it is determined that I can safely resume my prescribed weight loss regimen. Also, I declare that I am not breast feeding a child at this time.
8. I will consent to data obtained during my treatment being used in scientific presentations and publications with the condition that I am not identified by name in the published material and my anonymity will be preserved.

E. PROGRAM POLICIES

1. I understand that all program fees are NOT covered by insurance and are my responsibility. If my insurance does agree to pay for the program, I agree to pay all program fees up front to the program for weight management and have the insurance company reimburse me directly.
2. I understand that all HMP products are NOT returnable. Once I have purchased any of these products I will be unable to receive a refund or exchange.
3. I understand that laboratory fees are not included in my enrollment fee. These fees will be submitted directly to my insurance company by the laboratory. I will check with my insurance company to determine if regular blood draws are covered by my plan. Any portion of the lab fees that are not covered by my insurance are my responsibility.
4. I understand that any medication prescribed by a program for weight management physician is not included in the enrollment fee. I am responsible for the full cost of all medications prescribed to me.
5. I understand that formula sales are made at the discretion of the medical staff. The program for weight management will not sell formula to anyone if they have not been seen in the clinic for three or more weeks.

I have read and understand the above information and hereby agree and consent to treatment. I understand I may revoke this voluntary consent and discontinue my participation in the program for weight management at any time, but that this consent will be valid until revoked in writing by me.

Print Name: _____ Signature: _____

Witness: _____ Date: _____



Mediation and Dispute Resolution Agreement

Your care is important to us, and we feel it is vital to your treatment that we communicate openly and honestly. As such, we request that you: Ask questions and participate in your care, be honest about your history, symptoms, and other important health information, prepare for and keep scheduled visits, and be respectful to our office staff and healthcare providers. In exchange, we agree that we will: Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way, listen to your questions and help you make decisions about your care, keep discussions and records private, and determine when a referral or termination of care is appropriate.

MEDIATION

As a part of our emphasis on open communication, we ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or inference to a "claim" will be understood and read as "potential claim" until the mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff, and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

EXPERT WITNESSES

Further, if after mediation, you still wish to pursue a court action relating to your care, your signature on this page confirms that you will use, as your expert witness(es) in your legal action, American Board of Medical Specialties board-certified medical witness(es) in the same specialty as Physician. Furthermore, you agree that the physicians who you select will be in good standing and adhere to all of the rules and guidelines of professional conduct of the American Board of Medical Specialties. As consideration for this agreement, we agree that we will adhere to these same guidelines in selecting our expert witness(es) for any court action relating to your care.

PRINT PATIENT NAME

PATIENT SIGNATURE

WITNESS SIGNATURE

DATE

299 Carew St Suite 234
Springfield, MA 01104
413-787-2575

294 North Main St Suite 101
East Longmeadow, MA 01028
413-798-0301