

Changing Your Weighs Patient Information Form



General Patient Information: Update required yearly. This information is necessary for our files and will be considered confidential.

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Birthdate: _____ Age: _____ Gender: M F

Country of Birth: _____ Country of Parents' Birth: _____

Education: Elementary High School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. _____ 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. For your convenience, we accept Visa, MasterCard and checks.

I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge and will inform you of any changes in my health status or the information above.

I agree that should I cancel or reschedule an appointment with less than 24 hours notice, I will be assessed a \$25 fee that is due and payable at the time of assessment.

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

Patient's Signature

Date

HIPPA (Health Information Portability Accountability Act)

To protect your privacy as outlined by HIPPA, please indicate below who we may release medical information. We will need to know the name and relationship to the patient:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

May we leave messages regarding test results on your home answering machine? Yes___ No___

May we leave messages regarding appointments on your home answering machine? Yes___ No___

PRESCRIPTION REFILL POLICY

1. Prescription requests are during regular office hours only.
2. Contact your pharmacy for all Prescription Refill Requests. The Pharmacy should contact your Primary Care Physician directly.
3. FDA Controlled Medications can not be called into the pharmacy. Patients will be required to pick up a signed prescription at the office during regular business hours.
4. Patients will be required to schedule an appointment in the office for management of weight loss medications.

I have reviewed and read the above policy regarding Prescription Refills for all patients of Changing Your Weighs and do hereby acknowledge that I will abide by this policy.

Signature: _____

Date: _____

Changing Your Weighs Financial Policy

1. We accept: Cash, Check, Debit Card, Credit Card (Visa and Mastercard)
 2. We are not contracted with any insurance companies for services. Payment is expected in full at the time of service.
 3. Returned checks: A fee of \$25 will be charged for any checks that are returned by the bank for non-payment
 4. Once an account is placed in collection status, all future services must be paid in full at the time of service. Any balance assigned to collection agency will be assessed a 30% - 40% fee to offset the recovery expense.
 5. There will be a \$25 service charge for all documents that need to be completed by the provider.
 6. For scheduled office visits, there is a 24 hour cancellation notice policy. A \$25 service charge will be assessed for missed appointments or cancellation in less than 24 hours notice. Continued missed appointments may result in dismissal from the practice.
 7. Changing Your Weighs requires that a parent or legal guardian accompany all minor patients. The parent or legal guardian that accompanies the minor for medical services will be responsible for payment.

8. I hereby authorize the staff of Changing Your Weighs to provide me with medical treatment. I agree to inform Changing your Weighs if I have any concern about my medical treatment at the time services are being rendered.

ACCEPTANCE

I have read and understand the policies set forth and agree to abide by the terms of this policy. Furthermore, I attest that the information provided is accurate and I understand that it is my responsibility to inform the staff of Changing Your Weighs of any changes in address.

Signature: _____

Date: _____