Life Care Medical Weight Loss Center
8464 Adair Street Douglasville, Ga 30134
770-949-9810

Patient Information

Name/Date: _____

Address: _____
(Street Number & Name/City/State/Zip)

DOB/Age: _____

Social Security Number: _____

Home Number: _____ **Cell:** _____
Would you like to receive text message appointment reminders? YES NO

If yes please provide mobile carrier: _____

Email Address: _____
Would you like to receive email appointment reminders? YES NO

Name of Family doctor: _____

Emergency Contact (Name & Number): _____

Medical History

Please answer all of the following questions

1. Do you current have any allergies? If so please list Name/Medications/Reactions:

   _____

   _____

2. Is there any **medical history** for disease of the colon, liver, lungs, pancreas, small intestines, thyroid, lipids, hypertension, eye, stomach, prostate, urinary tract, or other?

   If so, please explain and give ***treatment*** regimen including ***medication(s)***:

   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____

3. Have you had any of the following **conditions**: heart attack, pulmonary hypertension, headaches, anxiety, depression, seizures, anemia, diabetes, fatigue, swelling, or other?

   If so, please explain and give ***treatment*** regimen including ***medication(s)***:

   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____
   - Condition/Treatment: _____

4. Do you currently, or have you ever in the past taken any medication for ADD/ADHD?

   If so, please explain when and give ***treatment*** regimen including ***medication(s)***:

   _____

   _____

5. Do you smoke? If so, how much? _____
6. Do you drink alcohol? If so, how much? _____
7. Have you ever been treated for drug/alcohol addiction? **YES** **NO**
8. Are you breastfeeding or possibly pregnant? **YES** **NO**
9. If applicable, when was you last menstrual cycle? _____

Personal Weight History

1. Do you have any illnesses that you believe may be the cause of your weight problem? **YES** **NO**

2. Has your weight changed over the past year? If so, how has your weight changed?

   a. _____

3. Were you overweight as a child? If so, at what age did you first notice/think that you were overweight? (*Estimate as best as you can*)

   a. _____

4. How much did you weigh at the following ages? *(Best Estimates)*

15_____ 18_____ 21_____ 30_____

FAMILY HISTORY

1. Are your any of your parents overweight? **YES** **NO**

   - If yes, please specify: _____

2. Are members of your immediate family (spouse, significant other, children, and siblings) overweight? **YES** **NO**

3. Family history of obesity/weight problems? **YES** **NO**

4. Family history of any of the following? (Mark all that apply)

	Mother	Father	Brother	Sister	Daughter	Son	N/A
Cancer							
Diabetes							
Heart Disease							
High Cholesterol							
Hypertension							
Infertility							
Obesity							

WEIGHT LOSS METHODS

1. Have you attempted to lose weight recently or in the past? If yes, at what age(s) did you attempt your weight loss and what method(s) were useD for each attempt?

   Age: _____ Method: _____

   Age: _____ Method: _____

Age: _____ Method: _____

2. Have you made and attempts at weight loss in the past year? If so, what medications (prescription/nonprescription), diet plans, exercise regimens (Gym's) and counseling have you tried?
    - Prescription/Non-prescription Meds: _____

      _____
    - Diet Plans: _____
    - Exercise Regimens: _____
    - Counseling: _____

DIETARY INTAKE & PHYSICAL ACTIVITY

1. What is your occupation? _____
2. Do you have individuals you normally eat with? **YES** **NO**
3. Are your eating companions overweight? _____
4. Do you feels that your dietary regimen may be influenced by your eating companions? **YES** **NO**
5. How do you expect your life to improve if you lose weight? _____

   _____
6. Does your current weight prevent you from participating in activities in which you like to be involved?
    a. If yes, please list some of those activities: _____

    b. _____
7. Please list some activities you would like to participate in if your weight was no longer an issue:
    a. _____

    b. _____
8. Do you have someone who will encourage you to adopt new behaviors or change your current behaviors? _____
9. How often do you exercise? _____
10. Do you have exercise companions? **YES** **NO**
11. Are your exercise companions overweight? **YES** **NO**
12.

TIMING

1. Why do you want to lose weight now? _____
2. Is this a suitable time for weight loss? _____
3. What is your goal weight? _____
4. Where did you hear of Life Care Medical Weight Loss Center? _____

   _____
5. Do you agree to a before and after picture? **YES** **NO**

The cost of this program and laboratory fees are non-refundable. I understand the physician's participation in the program is limited to supervision of the program **only**. Supervision includes review of laboratory test, history and periodic progress reviews. I do follow my Family doctor's advice for routine health care, physicals, and medications. For any medical problems or in case of an emergency, I will contact my family physician or my local emergency room for treatment.

Signature: _____

Date: _____

Thank you for your time!

Life Care Medical Weight Loss Center

Medical Weight Control

EXPLANATION OF MY PRACTICE POLICIES

The treatment of your weight problem is a difficult long-term endeavor. Unfortunately, this type of treatment is specifically excluded from some health insurance policies. Even if part of your treatment is covered by your health insurance, other parts probably will not be. We do not "participate" in any health insurance plans and I have signed no contracts with any health insurance carriers. _____ (Initial)

All of our fees are due at the time of service. _____ (Initial)

Our charge for each program visit is a global one which includes the office visit, usual specialized testing, and usual supplements or medications dispensed at the visit. If your case is an unusual one and requires medication, supplementation, or testing beyond the usual, your charge will be higher. Any medication that is filled at pharmacies will be not be covered by Life Care and at your own cost. _____ (Initial)

My services are specifically excluded from Medicare and Medicaid programs and they, unfortunately will not cover any part of your program if you are covered by either of them. We will provide a "superbill" with each visit which you can submit to your insurance carrier, if any, for reimbursement. Even though we charge a global fee for each visit, an itemization is provided on the relevant diagnosis or diagnoses on the superbill which we hope will help maximize your insurance reimbursement. I shall also include the relevant diagnosis or diagnoses on the superbill so that it will provide all of the information from us which is necessary to file an insurance claim. Most patients have found that the best course of action to follow is to immediately submit the first superbill to your insurance carrier. It should be attached to your insurance carrier's claim form in place of the "Physician information" section after you complete your part of the form. It is then best to continue to file after each visit. We regret that we are unable to enter into disputes between you and your insurance carrier. Of course, I cannot add or delete any appropriate diagnosis at your request any more than I could charge for a service I had not provided. Please save your superbill copies after each visit. _____ (Initial)

We regret that due to increased costs, we are forced to increase our charge for any un-kept appointments (not cancelled 24 hours prior to the appointment) to $25 per missed appointment, as well as occasional fees you may incur for walk in appointments. These fees are rarely reimbursed by the health insurance plans. _____ (Initial)

Because of the specialized and comprehensive nature of our programs, we are unable to discount our usual visit charge to patients who provide some of their own lab work, provide

their own vitamins, or who do not require the usual amount of medication or supplementation(**Subject to change at the Physician's or the Office Managers' discretion**).

After the initial physical, in order to insure proper medical care, we require a Complete Physical Exam performed once a year in this office. Dr. Moody's exam will be geared towards the specialty practice of Bariatric Medicine. _____ (Initial)

This is a specialized medical practice for weight related problems. You should also have a primary care physician to take care of your routine medical problems. I no longer provide regular general medical care.

Occasionally, I may treat you for a minor intercurrent medical problem at the time of your visit. This is done as a courtesy and a convenience to you. It does not replace your responsibility to get regular medical care for yourself and does not create an obligation for me to continue to treat you for such a problem out of my usual scope of practice. _____ (Initial)

Because this is a specialty medical practice dealing with a difficult and serious disorder, you should be aware that your treatment may involve the use of diets and medications which are often considered experimental by insurance carriers and various government agencies including the FDA. You may be treated with medications for indications not listed in the official FDA prescribing information ("off-label" users) or for longer periods of time or at higher doses than listed. I always welcome your questions about potential side-effects and feel that the benefit of any treatment should be considered as well as its risks.

We require that after you've read this statement in its entirety, that you sign and date below. Your initials are also required above for sections containing information that is important for you to read and understand. Please feel free to ask any questions you may have to our staff members to get a better understanding of things you may not understand. You signature below indicates that you have read this statement and understand it in its entirety.

_____ _____

Patient Signature Date