



Welcome to Integrated Medical Weight Loss!

Thank you for trusting us to help you achieve your weight loss goals. Our goal is to provide you with the support and tools for healthy and permanent weight loss.

Since we share so much information with you at the time we schedule your appointment we would like to summarize some important information & policies:

- Your first appointment will be approximately 1 hour. Your co-pay is due at the time of the visit. If you have a deductible, we will send you a bill after receiving the insurance EOB. With telehealth appointments being so popular now, we do ask for a credit card to be kept on file for payment of copays at time of appointments.
- Please complete your New Patient Forms prior to your appointment. Links for these forms will be emailed to you at the time of scheduling. If you are unable to complete them electronically, please call and we would be happy to mail a paper packet to you. If not received in advance, we will need to reschedule the appointment.
- If you have had recent lab work and EKG done and have copies of the results, it is helpful to include these with your paperwork.
- Many insurance plans require a **referral**. It is your responsibility to know if you need a referral and please request one from your primary care physician in time for your first appointment. If necessary, we are happy to help you obtain this.
- You will receive two automated confirmations for each appointment ~ a phone call one week prior, a text message 2 days prior. These can also be sent via email if preferred.
- We **require a 24-hour notice for all cancellations**. If you do not show up for your appointment or cancel in less than 24 hours you will be charged up to **\$75.00** for a follow-up visit and **\$100.00** for a New Patient Appointment.
- Our **prescription policy** is to provide refills at appointments, so please schedule accordingly.
- If for any reason our office will be closed (weather, power outage, etc...) we will send out an email, portal message and post a notice on our Facebook page.

If you have any additional questions, please don't hesitate to call, **401-886-9669**.

We look forward to meeting you!

Today's Date _____

Welcome to Integrated Medical Weight Loss!

Name _____ Date of Birth: _____ Sex: M / F

Home Address (City, State & Zip): _____

Email Address: _____

Cell Phone: _____ Home: _____ Work: _____

Employer Name/Address: _____ Occupation: _____

Circle One: *Minor Single Married Divorced Widowed Separated*

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about us? _____

Primary Care Physician (name & address): _____

Primary Insurance & ID#: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Preferred Pharmacy Name/Address: _____

Appointment Confirmation ~ Preferred Contact Method: Text Phone Call (cell or home) Email

Preference to send information: Email Patient Portal US Mail **Initial for approval** _____

List All Medical Problems **Medication for Problem / Dose** **Healthcare Provider for Problem**

Vitamins / Over the Counter Medication: _____

Allergies to Medications: _____

Mental/Emotional Problems **Medication for Problem** **Healthcare Provider for Problem**

List Any Surgeries **Surgeon** **Year of Surgery**

Number of Pregnancies: _____ # of Miscarriages?: _____ Complications? _____

Date of Last Physical: _____ Last Blood work: _____ Last EKG: _____

Have you had a Stress Test? _____ Results: _____ Sleep Study? _____ Results: _____

Have you had an "echo" ultrasound of your heart? _____

Have you ever taken Phen-fen / Redux? _____

School & Work History: _____

Hobbies: _____

Who lives with you? _____ Are you safe there: _____

Did / Do you smoke: Y N If so, # of packs/day: _____ Age Started: _____ Age Stopped: _____

Servings of Alcohol per day: _____ Other drug use: _____

Hours of sleep per night: _____ Do you think you have a problem with sleep? _____

Exercise: _____

Family Medical History Age Medical Problem If deceased—Age & Cause of death

Father: _____

Mother: _____

Sisters: _____

Brothers: _____

Children: _____

Spouse: _____

Other Important Family History: _____

When did your weight problem begin? _____ Highest weight (not pregnant): _____

Weight Loss Attempts:

Amount Lost	When?	What Method?"	Amount Maintained	Amount Regained

List Weight Gains: When ? Why do you think you gained ?

Are there food/eating triggers in your environment, including other people’s habits? _____

Do you ever feel like you “know what to do, but just can’t do it” when it comes to eating well? _____

Explain: _____

Do you think you have a problem with: **stress, emotional, mindless** or **compulsive eating**? (Circle all that apply) **Y / N**

Do you believe food or eating can be addictive for someone? _____ Do you think it is for you? _____

What is your most important / strongest motivation to lose weight? _____

How do you think we can help you lose weight? _____

Review of Systems - Please indicate personal history below:

Name: _____

Constitutional Systems

Good general health lately | No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

Eyes

Eye disease or injury No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double vision No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic Sinus problem or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

Cardiovascular

Heart trouble No Yes
 chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath w/walking No Yes
 Shortness of breath lying flat No Yes
 Swelling of feet, ankles or hands No Yes

Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Gastrointestinal

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

Genitourinary

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain w/periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - date of last pap smear No Yes

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

Integumentary (skin, breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose Veins No Yes
 Brest pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

Neurological

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness of tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head Injury No Yes

Psychiatric

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes
 Suicidal Thoughts No Yes
 Violent or Unusual Thoughts No Yes

Endocrine

Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

Hemotologic/Lymphatic

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Allergic/Immunologic

(History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics No Yes
 Morphine, Demerol or other Narcotics No Yes
 Novacain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin or other serums No Yes
 Iodine, Merthiolate or other antiseptic No Yes

Other drugs/medications:

Known food allergies:

Environmental allergies:

Past Medical History (Have you ever had the following):

Measles..... no yes	Anemia..... no yes	High Blood Pressure..... no yes	Kidney Disease..... no yes
Mumps..... no yes	Bladder Infections..... no yes	Low Blood Pressure..... no yes	Thyroid Disease..... no yes
Chickenpox..... no yes	Epilepsy..... no yes	Hemorrhoids..... no yes	Bleeding Tendency.... no yes
Whooping Cough..... no yes	Migraines..... no yes	Asthma..... no yes	Other (please list): no yes
Scarlet Fever..... no yes	Tuberculosis..... no yes	Hives or Exzema..... no yes	
Diphtheria..... no yes	Diabetes..... no yes	AIDS or HIV+..... no yes	
Smallpox..... no yes	Cancer..... no yes	Infectious Mono..... no yes	
Pneumonia..... no yes	Polio..... no yes	Bronchitis..... no yes	
Rheumatic Fever..... no yes	Glaucoma..... no yes	Mitral Valve Prolapse... no yes	
Heart Disease..... no yes	Hernia..... no yes	Stroke..... no yes	
Arthritis..... no yes	Blood Transfusions... no yes	Hepatitis..... no yes	
Venereal Disease..... no yes	Back Pain..... no yes	Ulcer..... no yes	



Integrated Medical Weight Loss

Patient Authorization to Disclose Personal Health Information (PHI)

Patient: _____ DOB _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Integrated Medical Weight Loss/Yestermorrow PC is authorized to **RELEASE TO / OBTAIN FROM**):

Recipient/Discloser: _____
Physician Name (use separate form for add'l doctor's)

For the Purpose of: _____
(optional)

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

I GIVE PERMISSION TO RELEASE **ALL** MY MEDICAL INFORMATION including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, Sexually Transmitted Infections (STI), Physical or Sexual assaults, communications to Physicians, Registered Nurse Practitioners, social workers and/or psychotherapies, psychologists, if any.

I GIVE PERMISSION TO DISCLOSE and/or RELEASE **ONLY** INFORMATION specifically described below (check all that apply):

- Consultations* *EKG* *History and Physical* *Outpatient Reports* *Emergency Reports* *Operative Reports* *X-ray Results* *Laboratory Reports* *Pathology Reports* *Mental Illness* *OT/PT* *Speech, Audiology* *Cardiac Rehab records* *Sexually Transmitted Infections* *Alcohol or Drug Treatment Test results & treatment* *Human Immunodeficiency Virus (HIV)*

I release Integrated Medical Weight Loss/Yestermorrow PC, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Integrated Medical Weight Loss/Yestermorrow P.C., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ (Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

Patient Signature (Patient's Representative if minor)

Date



Patient: _____

1. Financial Policy

We are happy you have chosen Integrated Medical Weight Loss for your healthcare and weight loss needs, and are looking forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. We suggest you contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we participate with, payment in full is expected at each visit. As a convenience, we offer discounted rates for self-pay patients.

Co-Payments and Deductibles: All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

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.

Thank you for understanding our payment policy. Please contact us if you have any questions or concerns.

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

Signature of Patient or Responsible Party

Date

2. Acknowledgement of Privacy Practice (HIPAA)

By signing below, I am consenting to allow Integrated Medical Weight Loss to use and disclose my PHI to carry out treatment, payment and healthcare operations. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read. I understand the Notice of Privacy Practices and agree to its terms.

Signature of Patient or Responsible Party

Date

3. PHI Disclosure Designation

I agree that Integrated Medical Weight Loss may disclose certain areas of my health information to a personal representative noted below, since such person is involved with my healthcare or financial responsibility related to my healthcare.

Name of Contact

Relationship to Patient

Signature of Patient or Responsible Party

Date



Patient Name _____

24 Hour Cancellation Policy Acknowledgement

As a courtesy, and to help patients remember their scheduled appointments, IMWL provides **two** (phone call/text/email) reminders for each appointment (1 week and 2 days in advance).

If you are unable to keep your appointment, we do require 24-hour notice. Please contact us so we can reschedule your appointment and accommodate those patients who are waiting to see our providers.

If you do not cancel or reschedule with at least 24 hours' notice, we will assess a **\$75.00** "no-show" service charge to your account. This no-show charge is not reimbursable by your insurance company.

Thank you for your understanding and cooperation with this policy.

Signature of Patient or Responsible Party

Date

Credit Card Information & Authorization

I hereby authorize Integrated Medical Weight Loss / Yestermorrow, PC to charge the credit/debit card listed below for the following charges (please check all):

- Copays Deductible Missed Appointment Fee (as outlined above)

I guarantee and warrant that I am the legal cardholder for this credit/debit card and that I am legally authorized to enter into this one-time or billing agreement. I understand that this office will not charge my credit card for anything other than the reason set forth in this agreement.

- VISA MasterCard Discover American Express

Card Holder name (as shown on card): _____

Billing Address: _____
Street City State Zipcode

Credit Card #: _____ Expiration Date: _____

Signature of Card Holder (Required)

Date

Notice of Privacy Practice

Integrated Medical Weight Loss (IMWL) is required by law to provide a Privacy Notice that describes how medical and health care information we maintain about you may be used or disclosed. Your protected health information (PHI) is confidential. This Notice describes each use and disclosure we are permitted to make, your rights, and obligations under the law.

Use and Disclosure: Under a variety of circumstances we may use your medical information without obtaining your prior authorization. We may use this information to provide you with treatment, ensure the quality of your care, bill and collect payment for services you received, report a communicable disease, domestic violence or criminal activity.

Your Rights: While the records we maintain belong to us, you have the right to correct, but not delete the information; choose where and how the information is sent to you; and obtain a list of non-routine disclosures.

Our Obligation: We are required to provide you with our Privacy Notice and abide by its terms. We may amend or change this notice without notification. If you have any questions, please call our office at 401-886-9669 and ask for the privacy officer. We are committed to keeping your information confidential. We store and manage your PHI primarily in our Electronic Health Record, although some records are stored in paper format.

How we may use and disclose PHI about You: We can release your PHI to provide, coordinate and manage your health care. This will include disclosing PHI to doctors, nurses, or other health care professionals who care for you. We may disclose your PHI to a physician to whom you have been referred so that the physician has the necessary information to treat you. We use your PHI to bill and collect payment for you, your insurance company, accountants or collection agencies or third party for the services you receive. We may use and disclose your PHI to contact and remind you of appointments. We disclose PHI when required to do so by federal, state or local law. We may use your PHI to tell you about or recommend possible treatment option health related benefits, promotional activities or services that may be of interest to you. We may release your PHI if we believe you have been a victim of abuse, neglect or domestic violence to the appropriate authorities. If possible, we ask your permission or notify you after the disclosure. We will disclose your PHI if court ordered or by governmental agencies authorized by law to audit or inspect the health care system. We will disclose your PHI in situations where you lack capacity to consent. We will not disclose psychotherapy, mental health treatment of drug and alcohol records unless you authorize such in writing.

Marketing: We will not make any disclosure of your PHI that would constitute marketing without your written authorization. We will not make any disclosure of your PHI that would constitute a sale of PHI without your prior written authorization.

Your Rights: You may ask that we limit how we use and/or disclose your PHI. You may ask that we send information to you by different means (i.e. mail). You may view or obtain a copy of your PHI. You cannot limit the uses or disclosures that we are legally required or allowed to make. You can complain if you feel we have violated your rights by contacting in writing the Secretary, U.S. Department of Health and Human Services, 20 Independence Ave., S.W., Washington, DC 20201. In the event of breach of PHI, we will notify you as required by law.

Minors and Personal Representatives: In most situations, parents, guardians, and/or others with legal responsibilities for minors (under 18 years of age) may exercise the rights described in the Notice on behalf of the minor. However, there are situations where minors may themselves exercise the right described here and minor's parents or guardians may not.

If you would like a copy of this condensed Privacy Notice for your records or to read the complete version of our Privacy Notice, please contact our office and we would be pleased to provide one to you.