# INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER

6038 W. Nordling Loop • Crystal River, Fl 34429 • Ph: (352) 563-5070 Fax (352) 795-4322

PATIENT NAME:______________________________________________

SOCIAL SECURITY NUMBER: ______________________________DOB:______________

ADDRESS: ____________________ ______________________________

ZIP CODE: __________ CITY: ________________________STATE: __________

HOME PHONE: ______________CELL PHONE: ______________WORK PHONE:______________

EMAIL ADDRESS: ______________________________________________

SEX: ❑ MALE FEMALE ❑ RACE: _____ MARITAL STATUS: SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑

EMERGENCY CONTACT: ____________________________PHONE:____________

CONTACT'S RELATIONSHIP TO PATIENT:______________________________

EMPLOYMENT STATUS: FULL ❑ PART-TIME ❑ RETIRED ❑ UNEMPLOYED ❑

EMPLOYER/SCHOOL: ______________________ PHONE: ____________________

## RESPONSIBLE PARTY

SAME AS ABOVE ❑ NAME: ______________________________________

SOCIAL SECURITY NUMBER:__________________________ DATE OF BIRTH: ______________

ADDRESS:______________________________________________

ZIP CODE: __________ CITY: ____________________________STATE:____________

HOME PHONE: ______________CELL PHONE :______________ WORK PHONE: ____________

**INSURANCE INFORMATION**

1 PRIMARY INSURANCE COMPANY NAME: ______________________________

CARDHOLDER'S NAME AS ON CARD: ______________________________

CARDHOLDER'S RELATIONSHIP TO PATIENT: __________CARD HOLDER SS#: ______________

CARDHOLDER' S DATE OF BIRTH ______________________________

INSURANCE ID #:____________________INSURANCE GROUP #: ____________________

SEND CLAIMS TO: ______________________________________

2. SECONDARY INSURANCE COMPANY NAME ______________________________

CARDHOLDER'S DATE OF BIRTH ______________________________

INSURED'S RELATIONSHIP TO PATIENT______________CARDHOLDER SS# ______________

INSURANCE ID # __________________INSURANCE GROUP # ____________________

**PAYMENT AND TREATMENT AUTHORIZATION**

I, the undersigned, authorize payment of medical benefits to Internal Medicine & Pediatrics Wellness Center P.L. and authorize the release of medical information necessary to process my insurance claim(s). I understand that I am responsible for all charges regardless of insurance coverage. ________ **Initials.**

I authorize my physician to provide immunizations and perform tests and procedures deemed necessary for my/ my child's care in the office _______**Initials**. I also consent to the release of information to a provider I am referred to for specialized care_________**Initials.**

**SIGNATURE**______________________________________ **DATE** ____________________

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WWW.IMPWELLNESSCENTER.COM

## ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I__________________________________acknowledge that I have received a copy of
(*Name of patient)*

Internal Medicine & Pediatrics Wellness Center's Notice of Privacy Practices. This Notice describes how Internal Medicine & Pediatrics Wellness Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

______________________________________________
(Signature of Patient, or Personal Representative) (Date)

______________________________________________
(Relationship to Patient)

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# *Disclosure of Protected Health Information*

By law, medical information is confidential unless written authorization is given. **Parent/Guardian of minors, those below 18yrs of age, have access to medical records, with the exception of any State Law protecting the privacy of information for minors**
In providing your care we may need to contact you or a significant other. Please indicate the things you are comfortable with:

Can we leave messages on your answering machine or voice mail ❑ Yes ❑ No

Can we email you ❑ Yes ❑ No

Can we call you at work ❑ Yes ❑ No

Is there anyone we can speak with about your medical care ❑ Yes ❑ No

Name ________________________________ Ph ______________________________________

Is there anyone we can speak with about your bill € Yes € No € Same as above

Name _______________________________ Ph _____________________________________

_____________________________________________ ______________________________
Signature of Patient or Legal Guardian Date

**Internal Medicine & Pediatrics Wellness Center**
6038 W. Nordling Loop • Crystal River, Fl 34429

# PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed 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.

**1. 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 expected 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.

**2. Co-payments and deductibles.** All co-payments and deductibles 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.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-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.

**4. 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 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 a claim.

**5. 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.

**6. 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.

**7. 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 treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing 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 patient or responsible party**

# IM&P Wellness Center
# Informed Consent for Weight Management

## *We want you to know...*

When you decided to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight.

The calorie deficit and portion-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974.

## *Your role...*

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem, eating activity and lifestyle patterns so your health care professional can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phases.
- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your sessions regularly if appropriate, and following your diet and exercise prescription.
- Allow your health care professional to share information with your personal physician.
- Make and keep follow-up appointments with your physician and have any blood tests taken or any other diagnostic measures made which your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by your health care professional and your physician.
- It is vitally important for you to advise the clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the clinic informed of any questions or symptoms you have, affords the best chance of intervening before a problem becomes serious.

If you do not have a personal physician, you must agree to find one before you and your health care professional begin working together. Your health care professional can assist you in this process if you like. Your signature below represents your permission, understanding and commitment to the above.

## *Potential benefits...*

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:

- Lower blood pressure, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see your physician as needed to have your need for these medications reassessed. Your health care professional will share your results with your physician on a regular basis so the physician is informed about your progress.

Other benefits may also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits, as well.

## *Possible side effects...*

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, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary. In addition, it is conceivable other side effects could occur which have not been observed to date.

**Reduced Weight.** When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. In addition, your body makes some other adjustments in physiology. Some of these are responsible, in some participants, for rapid improvements in blood pressure and blood sugar; other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, a slower heart rate, dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern, dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

**Reduced Potassium Levels.** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

**Gallstones.** Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstones (pain, diagnosed stones and/or surgery) in individuals 30 percent or more over desirable body weight (50 pounds or more overweight) not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 20-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals entering a weight loss program showed that as many as 1 in 10 had "silent" gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight--especially rapidly--may increase the chances of developing stones or sludge and/or increasing the size of existing stones within the gallbladder. Should any symptoms develop (the most common are fever, nausea and a cramping pain in the right upper abdomen or if you know or suspect that you may already have gallstones), let your physician and health care professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. A drug (Actigall®) is currently available which may help prevent gallstone formation during rapid weight loss. You may wish to discuss Actigall® with your primary care or weight management physician for more information.

**Pancreatitis.** Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

**Pregnancy.** If you become pregnant, report this to your health care professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

**Binge Eating Disorders.** Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one study to increase binge eating episodes temporarily. Several other studies demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

## *The risk of weight regain...*

Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets (including modified fasting) have shown varying results for percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program. A published medical study indicated people whose body weight fluctuates greatly or often have a higher risk of heart disease and death compared with persons of relatively stable body weight, and such weight fluctuations may play a role in the development of other chronic diseases.

**Sudden Death.** Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient.

## *Your rights and confidentiality...*

You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure the physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

By signing this Informed Consent, you state: I understand the information about my treatment in the weight management program offered by the clinic identified below is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others, I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

## *Resale of Products…*

The Nestlé HealthCare Nutrition products purchased through this weight management program, including OPTIFAST®, OPTITRIM®, etc, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any Nestlé HealthCare Nutrition products purchased through this weight management program.

***I, the undersigned, have reviewed this information with my health care professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.***

______________________________ ______________________

**Participant Signature** **Date**

***I have received a copy of this signed consent form.***

______________________________ ______________________

**Participants Initials** **Date**

# IM&P Wellness Center
# Informed Consent for Appetite Suppressants

**I. Procedure and Alternatives:**

1. I,_____________________________________________ (patient or patient's guardian) authorize The medical team at IM&P Wellness Center to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

> "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.
>
> "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
>
> "As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

**II. Risks of Proposed Treatment:**

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

**III. Risks Associated with Being Overweight or Obese:**

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

**IV. No Guarantees:**

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

**V. PATIENT SINGNATURE DO NOT SIGN UNTIL YOU HAVE HAD YOUR QUESTIONS ANSWERED**:

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, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

**DATE:**_________________________________ **TIME:**_________________________________

**PATIENT:**____________________________________________________**WITNESS:**_______________________________________________

# RESTING METABOLIC RATE WORKSHEET

The resting metabolic rate (RMR) test is performed in our office. This test is a direct measurement of the calories your body uses when at rest. This gives a more precise and realistic gauge for the rate at which we expect you to lose weight. This test is strongly recommended especially for those who have found themselves in the position of dieting but not losing weight. We usually bill this to your insurance if it is not covered you will receive a bill for sixty dollars. To accurately perform this test you must fast be fasting a minimum of four hours prior to your appointment.

**NAME:** ______________________________________________

**DATE OF BIRTH:** ________________________

**AGE:**_________________________________

**GENDER:** ( ) MALE ( ) FEMALE

**IF FEMALE:** ( ) PREGNANT ( ) LACTATING ( ) NEITHER

**OCCUPATION:** ______________________________

WORK SCHEDULE: HOW MANY HOURS DO YOU WORK PER WEEK?

| DAY | MON | TUES | WED | THURS | FRI | SAT | SUN | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| NUMBER OF HRS | | | | | | | | |

**SLEEP SCHEDULE**: ON AVERAGE HOW MANY HOURS DO YOU SLEEP PER NIGHT?

WORK DAY:

NON WORK DAY:

**EXERCISE PLAN:**

HOURS PER WEEK TOTAL:

WHAT TYPE: ( ) WALKING

( ) RUNNING

( ) SWIMMING

( ) OTHER – EXPLAIN:

**TARGET WEIGHT:** _____________**LBS**

# WHAT TO EXEPECT WITH WEIGHT MANAGEMENT VISITS

Congratulations on taking that all important step to loose weight. Our team at IM&P Wellness Center are sensitive to your struggles with weight and appetite control. We are here to help you succeed. We will cheer you on and comfort you on this life changing journey. Weight Management is a life long journey and we are here to help you.

**A. INITIAL VISIT**

Your initial visit will consist of a complete history and physical exam to asses your mental and physical status before starting the program.

Labs required : Complete blood count (CBC) Comprehensive metabolic panel (CMP) Lipid Panel Thyroid function TSH w/ Reflex to T4. Within the past month. 12– lead Within the last 3 mths.

**B. WEEK ONE**

You week 1 appointment will include a Resting Metabolic Rate (RMR) analysis . You are advised to complete the RMR sheet prior to your appointment. Please remember to fast for 4 hour prior to this appointment.

**C. FOLLOW-UP VISITS**

1. Clinic hours are from 10 am to 6 pm
2. Weekly when you come in for clinic you will check in with the receptionist.
3. You will be given a Products Order form.
4. Once you complete it return the form to the receptionist.
5. Product payment will be due at this time.
6. You can then have a seat in the waiting room.
7. The Medical Assistant will call you in to obtain your weight, B/P and pulse.
8. If you are due for any lab work or a visit with your physician the Medical Assistant will take you to the exam room or draw your lab.
9. You will then proceed to check out after your visit where your products will be waiting for you.