

Statement of Philosophy

1. Obesity is a chronic disease, which requires a lifelong treatment.
2. Obesity is a disease process with a physiological cause, like diabetes or hypertension. It is **not** a result of “**weakness**” or “**lack of willpower**” on the part of the patient.
3. Obese individuals have a right to healthcare that is safe and fits their lifestyle. It should recognize and respect their individual, physical, social, spiritual, psychological and economic needs.

Center for Medical Weight loss

Patient History

Name _____ Age _____ Gender _____
DOB _____

How did you hear about us? _____

What condition(s) bring you to our office today? _____

List all past and current medical problems _____

List all prior surgeries and dates _____

List all current medications and dosages _____

Family History (ie: cancers, heart disease, diabetes, stroke, etc.) _____

Occupation _____

Allergies to medications _____

Do you or have you smoked? Y N packs/day _____ for _____ years, quit in _____

Do you drink alcohol? Y N drinks per week _____

Center For Medical Weight Loss

Additional History Questions

Have you had any of the following medical conditions? (Please circle any that apply)

1. Gallstones
2. Kidney problems
3. Liver problems
4. Heart failure
5. Heart attack
6. Low sodium or potassium
7. Bipolar Disorder
8. Heart rhythm abnormalities
9. Pancreatitis
10. Anorexia or Bulemia
11. Drug addiction
12. Rheumatic disease (Lupus, Rheumatoid Arthritis)
13. Lung problems

_____ Date _____
Name

Signature

The Center for Medical Weight loss

6363 West 120th Avenue, Suite 302
Broomfield, Co 80020

Patient Information

Home Phone (____) _____ Cell Phone (____) _____ Work Phone(____) _____

Name _____ SS# _____
Last Name First Name MI

Address _____ Email _____
City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Married Widowed Single Separated Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone(____) _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____

Primary Care Provider _____ Phone(____) _____
Name

Fax(____) _____ Address _____ City _____
State _____ Zip _____

Primary Insurance

Person responsible for the account _____
Last Name First Name MI

Relationship to patient _____ Birthdate _____ SS# _____

Address (if different from patient) _____ Phone(____) _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber# _____

Names of other dependents covered under this plan _____

Assignment and Release

I certify that I, and/or dependent(s), have insurance coverage with _____ and assign directly to Dr. Janowski all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature _____ Date _____

Please print name _____ Relationship to patient _____

WEIGHT CONTROL EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us? _____

How much weight do you expect to lose? Each week? Each month?

What other weight loss programs/measures have you tried?

.....

What was your lowest adult weight?.....Highest?.....

What activities or situations can you not participate in as a result of your weight?

.....

What size clothes do you expect to be able to wear when you reach your goal weight?

.....

What do are your expectations of us (your medical counselors)? Be specific:

.....

What changes in your life would you like to see when you reach your goal weight?

.....

.....

What do you expect to have to do to maintain your weight loss?.....

.....
Do you eat while driving?.....While watching TV?.....

How many hours of exercise per week do you currently do?.....

How many hours of TV per week do you watch?.....

How many times per week do you eat fast food?.....

Do you travel frequently?.....

How often do you eat for reasons other than feeling hungry?.....

Do you find it difficult to avoid “cleaning your plate”?.....

Do you have difficulty falling or staying asleep?.....

How stressful is your life?.....

Name some foods you eat frequently:.....

.....
.....

What do you feel are your most significant barriers to your success in losing weight?.....

.....
.....
.....
.....
.....

Patient Name: _____ **Date:** _____

Email Address: _____

By signing this form, I understand that I may receive email communication from The Center for Medical Weight Loss from time to time related to my weight loss program. I also understand that I may elect to stop receiving such emails at any time by using the “unsubscribe” link located at the bottom of the email communication.

The Center For Medical Weight loss Notice of privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect upon your first visit and remains in effect until we replace it.

1. Our pledge regarding medical information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our legal duty

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy and the new terms of our notice effective for all medical information that we keep, including information previously created or received before changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

2. Use and disclosure of your medical information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your information for any purpose not listed below, without your specific written authorization. Any specific written authorization you may provide may be revoked at any time by writing us.

For treatment: We may use medical information about you to provide you with a medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information.

For healthcare operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility; your condition described in general terms; your religious affiliation,

if any. We may disclose this information to members of the clergy or except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use or disclose medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use or professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may chose not to receive future fundraising communications.

Research in limited circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral director, coroner, medical examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized government functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the president and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court orders and judicial and administrative proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstance.

Public health activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the food and drug administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacement, to track products, or to conduct activities required by the food and drug administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of abuse, neglect, or domestic violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health oversight activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Law enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds,) pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointment.

Alternative and additional medical services: We may use and disclose medical information to furnish you with information about health related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

3. **Your individual rights**

You have the right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format that you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using our contact information. If you request copies, we will charge you \$0.50 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.)
4. Request that we communicate with you about your medical information by different means or to different locations. You request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person at our office.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change information, we will make reasonable efforts to tell others, including people you name, of the changes and to include the changes in any future sharing of that information.
6. If you receive this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person at our office.

By signing this form I am stating I have received a copy of the HIPPA privacy policy.

Signature

Date

Printed Name