Center for Weight Loss Success, P.C.
Patient Data Sheet

PLEASE WRITE LEGIBLY **DATE**_____

Name of Patient_____
Last *First (Jr., Sr. optional)* *Middle* *Nickname*

Date of birth:_____ Sex: ____ Male ____ Female SS#_____

Home address:_____
(cannot accept P.O. Box as home address) *Street* *Apt#/Bldg#* *City* *State* *Zip code*

Mailing address:_____
Street *Apt#/Bldg#* *City* *State* *Zip code*

Home #_____ Work #_____ Cell #_____

E-mail address:_____ Can we contact you via E-mail:_____Yes _____ No

How do you prefer that we contact you? ____e-mail OR _____ phone

Occupation:_____ Employer&Address_____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Level of Education: _____

Spouse's name:_____ Phone number:_____

Guarantor Information/Person Financially Responsible for Patient Bill

Guarantor's name:_____ Date of birth:_____

Social Security number:_____ Home phone:_____ Work:_____

Primary

Insurance_____Address_____

Subscriber_____Subscriber Date of Birth_____

Insurance Phone#_____ Policy#_____ Group#_____

Secondary

Insurance_____Address_____

Subscriber_____Subscriber Date of Birth_____

Insurance Phone#_____ Policy#_____ Group#_____

Who should we contact in an emergency?

Name:_____ Relationship:_____ Phone:_____

Who is your primary care physician (PCP)? Dr._____
First *Last* *Phone #*

Who referred you to us? _____

Center for Weight Loss Success, PC - General/Financial Consents

FINANCIAL POLICY

I understand that payment is due at the time of service. I also understand that purchase of any weight loss surgery or medical program will have an individualized term of agreement document for me to review and acknowledge prior to purchase. I acknowledge that for any surgical care, payment must be received prior to surgery and I understand that non-payment will result in surgery cancellation. I acknowledge that no goods or services provided by the Center for Weight Loss Success are refundable at any time. This includes, but is not limited to, program fees, supplements, exercise accessories and personal training sessions. Supplements and exercise accessories may not be returned.

I understand that at the completion of any weight loss program I have selected and paid for, all contents and offers including but not limited to, counseling sessions, and supplements, will expire and are not redeemable. For medical weight loss, I am required to start my program within the time frame of the program selected from its initial purchase date. Deposits expire within 3 months from the initial purchase date. However, deposits are not transferrable toward any other products, services or programs. Personal training sessions, lifestyle education classes, group exercise classes and/or counseling sessions purchased separately will expire 6 months from the date of purchase. I also understand that there will be a **$35.00 returned check fee** (paid only by money order, cashier's check or cash) for each check returned for insufficient funds.

I understand that co-pay's (when applicable) are due at the time of service and I am responsible for any balance un-paid by my insurance, and that it is not the responsibility of Center for Weight Loss Success to be sure that my service(s) are covered, thus I understand that any questions that I have concerning my insurance coverage should be directed to my insurance company. I also understand that, **if my insurance requires a referral** for specialist visit, it is my responsibility to obtain (referral) from my PCP, and that my signature below also acts as a *waiver* accepting financial responsibility if my insurance requires a referral and **I choose to receive services without one**.

REQUEST FOR RELEASE OF MEDICAL RECORDS OR INFORMATION

I authorize the release of any and all medical records, reports, imaging studies, labs, operative/path reports, visual data, and any other requested information relating to my care at any facility including, but not limited to physicians, clinics, hospitals, or other locations where I may have had tests/treatment. This material may be released to the Center for Weight Loss Success, PC by FAX at (757) 873-1990 or other means, and I authorize the use of a copy of this form to be treated as an original request in obtaining the material or data. Center for Weight Loss Success, PC staff has my full permission to obtain this data on my behalf. I also authorize release of my medical records relating to my care and/or FMLA/Disability FROM Center for Weight Loss Success, PC TO physicians/medical facilities/employer(s) and/or insurance company(s).

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to body fluids of a patient in a manner which may have transmitted human immunodeficiency virus (HIV). Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained to you and you would be given an opportunity to ask any questions you might have.

My signature below is my consent that I understand and agree that the terms above apply to my current and future services at Center for Weight Loss Success, PC.

Print Name:_____ Signature:_____
Date:_____

WRITTEN ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES
Center for Weight Loss Success, PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Privacy Officer is Cat Williamson

Our Notice of Privacy Practice provides information about how we may use or disclose medical information about you. You may request a copy of our notice at any time.

I,_____(please print patient name) have been provided a copy of Center for Weight Loss Success, PC Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practice (Available at CFWLS)

I understand that I may ask questions to Center for Weight Loss Success, PC, Privacy Officer if I do not understand any information contained in the Notice of Privacy Practice.

_____
Patient Signature

_____
Date

_____
Authorized Representative of Patient

_____
Relationship to Patient

_____
Date

<u>Important information regarding the following consent:</u> During your upcoming appointment with Dr. Clark, he will refer to the information provided in his weight loss surgery webinar. Although it's possible that you have viewed or attended weight loss surgery classes in the past, it is required that you view *Dr. Clark's* webinar, as the information is specific to *his* weight loss surgery program. The webinar can be located on our website at www.cfwls.com.

This statement is my acknowledgement that I have viewed Dr. Thomas W. Clark's surgical webinar in full.

I agree that the surgical webinar provided thorough education on Banded Gastric Bypass, Laparoscopic Adjustable Gastric Banding and Laparoscopic Sleeve Gastrectomy. Discussion for each procedure **<u>included</u>** but was not limited to:

- short and long term risks
- weight loss results
- surgery and recovery times
- positives and negatives
- importance of incorporating nutritional education, exercise, and behavior modification for best chance of long term success

Although Dr. Clark offers a *live* weight loss surgery seminar I have opted to view his webinar. I agree that I understand the information discussed in the surgical webinar and will have the opportunity to ask questions about my personal situation during my one on one consultation.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF INSURANCE VERIFICATION FOR WEIGHT LOSS SURGERY

(For Patients Who are Hoping to Use Insurance for Weight Loss Surgery)

Did You Know: If your insurance is administered through your employer, that it is the *decision* of your employer (as to) whether or not the benefit (ryder) for weight loss surgery is available on your policy?

Prior to your appointment with Dr. Clark it is important that you have verified (that) this ***ryder*** which is specific to weight loss surgery is in place. This can be done by calling the member/customer service number on your insurance card; choose the option for eligibility and/or benefits; ask the question "*Do I have the morbid obesity ryder on my policy*?" If the answer is yes, ***and*** you meet the national BMI requirements (listed below) for weight loss surgery, then CFWLS has professional staff who will guide your through fulfilling your pre-approval requirements. If the answer is no, then unfortunately this means that your insurance company is ***contracted*** with your employer to "*close the door*" ie: *deny* the pre-approval request for weight loss surgery, even starting with the one on one consultation.

If you find out that your insurance doesn't cover weight loss surgery and you would like to explore Dr. Clark's self-pay Sleeve Gastrectomy program (lowest cost on the east coast with the most comprehensive program and financing options available), give our office a call or visit our website at www.cfwls.com.

Patient's with Medicare - Dr. Clark is not a provider of Medicare and/or Medicare products. If you have an upcoming appointment with Dr. Clark and this has not been discussed, please call our office prior to your appointment to assure that your questions concerning options have been answered.

Patient's with United Healthcare – Although Dr. Clark is a provider of United Healthcare, the hospital where surgery is performed (Sentara Careplex Hospital) is not on the UHC/Optum list of preferred facilities *specific to bariatric surgery*

Insurance BMI (Body Mass Index) Requirements for Weight Loss Surgery – Insurance companies with the weight loss surgery ryder in place typically recognize coverage **(1)** For patients who have a BMI of 40 or greater OR **(2)** For patients who have a BMI as low as 35 ***if*** a clinical diagnosis of diabetes, high blood pressure or sleep apnea are present. You can calculate your BMI by going to https://www.nhlbi.nih.gov/ and type *calculate your bmi* in the search bar.

If you have questions concerning any of the information provided on this paper, please give our office a call. Otherwise, your signature below is acknowledgement of your understanding.

_____ _____

Patient Signature Date

Please take a few minutes to answer the following questions and return this prior to leaving the office today. This information will help our staff best serve your needs. This information is also needed for the surgeon to complete a thorough review of your chart.

Today's Date:_____ Name:_____

Date of Birth:_____ Zip: _____

I am interested in proceeding with surgery in:

- ☐ **0-3 months (make sure you schedule your computer test and psychologist appointment as soon as possible)**
- ☐ **3-6 months**
- ☐ **Sometime within the next year**
- ☐ **Unsure – I need additional information**

How did you hear about our office?

☐ **Drive By** ☐ **TV** ☐ **Radio** ☐ **Internet Ad**

☐ **Internet Search:** ☐ **Sentara.com** ☐ **CFWLS.com** ☐ **Riverside.com** ☐ **Other**

☐ **Your physician(s) (Please Specify) _____**

☐ **Riverside Physician** ☐ **Sentara Physician** ☐ **Other _____**

☐ **Friend/Previous Patient (Please Specify so we can thank them) _____**

Interested in receiving our newsletter and other weight loss information from Dr. Clark? ☐ YES ☐ NO

Please provide your E-mail address below

We do not share your information with anyone else. You may stop receiving information at any time.

How may we BEST contact you?

Telephone: _____

Email address: _____

DIET HISTORY

Patient Name:_____Signature:_____

Date:_____

PROGRAM	MO./YR. START & END	WT. LOSS	WT. GAIN
WEIGHT WATCHERS	_____	_____	_____
WEIGHT LOSS FOREVER	_____	_____	_____
ATKINS	_____	_____	_____
NUTRA SYSTEM	_____	_____	_____
JENNY CRAIG	_____	_____	_____
PROTEIN SHAKES	_____	_____	_____
METABOLIFE	_____	_____	_____
LOW CALORIE	_____	_____	_____
HIGH PROTEIN	_____	_____	_____
KETO	_____	_____	_____
DIET PILLS	_____	_____	_____
NUTRITIONIST	_____	_____	_____
LOW FAT	_____	_____	_____
B12 SHOTS	_____	_____	_____
OTHER	_____	_____	_____
OTHER	_____	_____	_____
OTHER	_____	_____	_____

CENTER FOR WEIGHT LOSS SUCCESS, PC
HEALTH /LIFESTYLE EVALUATION

Patient Name:_____
Date Completed:_____

DO NOT LEAVE ANY LINE BLANK – MARK N/A IF IT DOES NOT APPLY

Date of Birth_____Age_____Marital Status M___S___D___W___Occupation_____

Height_____ Weight_____How long at this weight?_____Goal weight_____

Primary Care Physician_____How long has He/She been your PCP? _____

PCP Address_____ Phone Number_____ Last Exam_____

Other physicians treating you?_____

Health conditions currently being treated: _____
_____
_____
Have you ever been under the care of a psychiatrist or psychologist? □ No □ Yes

If yes, with whom and when? _____

Treatment plan: □Counseling □ Hospitalization □ Medications: _____
Still under treatment? □ Yes □ No

DO YOU HAVE OR HAVE YOU HAD	YES	NO	DON'T KNOW
Diabetes			
High Blood Pressure			
High Cholesterol			
High Triglycerides			
Angina/Coronary Artery Disease			
Heart Attack			
Heart Arrhythmia			
Sleep Apnea			

LIST OF CURRENT MEDICATIONS: (Include OTC & Vitamins)

NAME OF MEDICATION	STRENGTH	HOW OFTEN	REASON FOR MED

Medication Allergies: □ No □Yes If yes, please list:
_____
_____

LIST ANY MAJOR ILLNESSES:

Illness	Date	Treatment	Outcome

LIST ANY SURGERIES:

Surgery	Date	Reason

FAMILY HISTORY

	YES	NO	MOTHER	FATHER	SIBLING	CHILD
Being Overweight						
Diabetes						
High Blood Pressure						
Heart Disease						
Stroke						
Arthritis						
Cancer						
Thyroid Disorder						

GYN HISTORY (If Applicable)

Yes No Have you been treated for infertility?
Yes No History of PCOS
Yes No Regular Menstrual Periods
Yes No Menopausal
If yes, year of onset_____
Yes No Pregnancies
If yes, number of deliveries_____
Other: _____

Who is your Ob/Gyn physician? _____

URINARY PROBLEMS

Do you ever involuntarily lose your urine? Yes_____ No_____

HEARTBURN AND/OR INDIGESTION

Do you have indigestion or heartburn? Yes_____ No_____ If yes, for how long_____

Have you ever had an endoscopy? Yes_____ No_____ If yes, date of procedure_____

Have you ever had a colonoscopy? Yes_____ No_____If yes, date of procedure_____

BREATHING PROBLEMS

Have you been evaluated by a pulmonologist? Yes_____ No_____ If yes, complete the following:

Name of physician_____ Phone number_____

Do you experience shortness of breath with physical activity? Yes_____ No_____

Do you snore? Yes_____ No_____

Have you been diagnosed with sleep apnea? Yes_____ No_____

Do you use a C-Pap or BI-Pap machine? Yes_____ No _____

Do you ever stop breathing while asleep? Yes_____ No_____

Do you have or have you had asthma? Yes_____ No_____

Do you suffer with chronic bronchitis? Yes_____ No_____

BONE OR JOINT PROBLEMS

Do you have any of the following: Please Indicate

LOCATION	SWELLING	PAIN	STIFFNESS	POPPING/CRACKLING
Ankle				
Knees				
Hips				
Back				
Other				

Have you ever been told you have degenerative change or early arthritic changes in your joints? Yes_____ No_____ If yes, please explain:_____

Have you ever been treated for bone or joint problems? Yes_____ No_____ If yes, Please indicate (including physical therapy and chiropractic)_____

Yes No Have you ever smoked cigarettes?
If yes, what was the most you ever smoked? _____
How much do you smoke now? _____

Yes No Do you drink coffee or tea?
If yes, how many caffeinated cups do you drink per day? _____
How many decaffeinated cups do you drink per day? _____

Yes No Do you drink cola or soft drinks?
If yes, how many caffeinated drinks per day? _____
How many decaffeinated drinks per day? _____
Please specify: _____regular soda_____ diet soda

Yes No Do you drink alcohol?
If yes, how many servings do you drink per day? _____
Please specify: ____beer ____wine ____liquor _____other

Yes No Do you ever feel out of control with your eating?
If yes, please describe how this feels and how often this occurs
_____

Do you have or have you ever had any of the following symptoms/problems/concerns?

YES	NO	SYMPTOM/PROBLEM/CONCERN	DETAIL/COMMENTS
		High Blood Pressure Readings	
		Elevated Blood Sugar Readings	
		Frequent or Severe Fatigue/Weakness	
		Polycystic Ovarian Disease	
		Frequent or Severe Headaches	
		Nasal Congestion	
		Chronic Sinus Congestion	
		Dental Problems	
		Dentures	
		Heart Murmur	
		Chest Pain with Activity or Exercise	
		Heartburn	
		Pain or Discomfort after Eating	
		Bloating	
		History of Kidney Problems	
		History of Liver Problems	
		History of Hepatitis	Type:
		History of HIV Infection	
		Anemia	
		Constipation	
		Bleeding Tendency	
		Convulsion or Seizures	
		Paralysis, Numbness or Tingling	
		Slow Metabolism	
		Depression	
		Anxiety	
		Sleep Problems	
		Drug or Alcohol Abuse	
		Chronic Skin Rash or Hives	
		Chronic Skin Infections of Lower Legs	
		Chronic Skin Infections Under Breasts	
		Varicose Veins of Legs	
		Gout	
		Fibromyalgia	
		Shortness of Breath when Walking	
		Chronic Pain	
		Anorexia	
		Bulimia	
		Suicidal Thoughts/Attempts	

Being Overweight has affected:

- ❑ Family Life
- ❑ Social Life
- ❑ Emotionally
- ❑ Unable to find a job
- ❑ Exercise or Sports

Reviewed by:_____ Date:_____

Phone (757) 873-1880
Fax (757) 873-1990

Sleep Apnea Risk Assessment Form – Fax 757-827-2199

PLEASE CALL PATIENT BELOW TO MAKE AN APPOINTMENT

The problem of sleep apnea is very common among our patient population. Sleep apnea can affect your overall health and is important to diagnose and treat. We also find that the diagnosis of sleep apnea can **expedite** your insurance approval process for weight loss surgery. Please take a minute to fill out this screening questionnaire.

Have you been diagnosed with sleep apnea? □ Yes □ No □ I don't know

Parameter	Question		Score
Snoring	**Do you snore loudly (louder than talking or loud enough to be heard through closed doors?**	**□ No= 0 □ Yes = 1**	
Tired	**Do you often feel tired, fatigued, or sleepy during daytime?**	**□ No= 0 □ Yes = 1**	
Observed	**Has anyone observed you stop breathing during your sleep?**	**□ No= 0 □ Yes = 1**	
Blood Pressure	**Do you or are you being treated for high blood pressure?**	**□ No= 0 □ Yes = 1**	
BMI	**BMI _____kg/m2 . Is the BMI more than 35 kg/m2?**	**□ No= 0 □ Yes = 1**	
Age	**Age over 50 years old?**	**□ No= 0 □ Yes = 1**	
Neck Circumference	**Neck circumference measured ____(inches or cm) or indicate collar size of shirt, i.e., S, M, L, XL, or ____. Neck circumference greater than 16 inches (40cm)**	**□ No= 0 □ Yes = 1**	
Gender	**Gender male?**	**□ No= 0 □ Yes = 1**	
		Total Score	

If your score is 3 or more, there is a significant chance that you have sleep apnea.

We would be happy to refer you to one of the Sentara Sleep Centers for evaluation (Hampton or Williamsburg)

□ I would like to be evaluated further and consent to referral □ Not at this time

I would prefer: □ Hampton □ Williamsburg

Name (print)_____ Phone_____ ☐Cell ☐ Home

Signature_____ Email_____