



WEIGHT LOSS CHART

2019



321 S Patrick St.
Alexandria, VA 22314
703.549.2626
F: 703.299.5080



Please Fill Out Completely

Patient's Name: _____
Last First Initial

Home Ph#: _____ Business Ph#: _____

Cell Ph #: _____ Date of Birth _____
(Required for medical screening)

Home Address: _____
Street

_____ City State Zip

E-mail Address: _____

Nearest Relative Name: _____

Address: _____ Ph #: _____

How did you hear about us?

- | | |
|-------------------------------|--------------------|
| _____ Yellow Pages | _____ Drive-by |
| _____ Mail | _____ Newspaper Ad |
| _____ Other | _____ Office Sign |
| _____ Friend of DWLC, Patient | _____ Website |
| _____ Name _____ | _____ Physician |
| | _____ Name _____ |

Have you used a professional weight loss/management program in the past? If yes, which one(s)?

Jenny Craig _____ Weight Watchers _____ Physician's Weight Loss _____
Other Doctor _____ Other _____

Comments: (Did you lose weight? Did you receive counseling? Were you on prescription medication? If so, provide the name.)

Please ask about our referral program.

Medical & Family History (Please check the ones that apply)							
Health Care Problem	Self	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Cancer (type or location)							
Heart Disease							
High Blood Pressure							
Stroke							
Lung Disease							
Tuberculosis							
*Diabetes (See page 4)							
Kidney Disease							
Liver Disease							
Thyroid Disease							
Bleeding Disorder							
Epilepsy/Convulsions							
Osteoporosis							
Mental Illness							

*Diabetics must comply with monitoring. See page 4 for details.

Current Medical History – Please print // list your current medication(s) and reason(s):

_____ (Required for medical and prescription medication screening)

Are you allergic to any medications? ____ Yes ____ No

Please List:

Hospitalization or Surgery –Write in the reason and the date

PAST MEDICAL HISTORY – Check all that apply (For immunizations, place a √ and dates (year))		
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Depression	<input type="checkbox"/> Gall Bladder Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Bowel Irregularity
<input type="checkbox"/> Measles	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Mumps	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sexual/Menstrual Dysfunction
<input type="checkbox"/> Polio	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Breast Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Rubella	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Gout
<input type="checkbox"/> Other Immunizations	<input type="checkbox"/> Asthma	<input type="checkbox"/> Abnormal PAP/Mammogram
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pregnancies (Number)
<input type="checkbox"/> Chronic Rashes	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Live Births (Number)
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Abnormal TB skin test	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> GI Disorder	<input type="checkbox"/>
<input type="checkbox"/> Headache	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/>

Do you want your primary physician to be informed of your progress during the course of this program? ___ Yes ___ No

Name _____ Ph#: _____

Lifestyle

Do you smoke or use tobacco products? ___ Yes ___ No
 How much do you use on a daily basis?
 Number of cigarettes _____ Number of Cigars _____ Amount of chewing tobacco _____

Do you drink alcohol? ___ Yes ___ No
 How many glasses do you consume on a weekly basis? _____

Do you currently exercise? ___ Yes ___ No
 If so, what kind of exercise and how often? _____

Patient Weight Goals

How much total weight do you want to lose? _____lbs Present weight _____ lbs

What is your height? _____

How fast? (Check one)

_____ 5 to 8 pounds per month _____ 10 to 12 pounds per month
_____ 15 to 20 pounds per month

What is your present dress/pant/suit size? _____ What size would you like to wear? _____

Financial/Refund Policies and Patient Responsibility:

- There are **no refunds** for services rendered for our weight management fees. All applicable payments must be made in advance of service. We offer no payment plans.
- **Health Insurance is not** accepted by Doctor’s Weight Loss Centers, Inc.
- Individuals with flexible spending accounts will receive appropriate documentation to receive reimbursement from their employer. Allow 5-7 working days for preparation.
- Patient will pay for follow-up lab work at their own expense every 4 months to remain on prescription medication and provide current EKG and physical upon request.

I attest that all the above information is true. I have also read and understand the refund / financial policies and patient responsibility mandated by Dr. Heron and the Doctor’s Weight Loss Center’s staff.

Patient Signature: _____ Date: _____

FOR PATIENT’S WITH DIABETES:

If you ARE a *diabetic and take prescription medication for your diabetes, you MUST visit with your primary care physician for close monitoring of your medication and sugar levels while on our weight loss program. A signed agreement from your physician must be provided for your file BEFORE you are accepted on our weight loss program. Failure to do so will expel you from our program.

Patient Signature: _____ Date: _____

Cancellation Policy

Dear Patient:

Quite a few patients want to be seen. We know you want to be seen in a timely manner. In order to accomplish this, I schedule the appropriate number of patients to be seen in a set time. That is my responsibility to you. I ask that, in return, you respect my time as well as other patients.

If you cannot keep your appointment, CALL TO CANCEL, 24 hours before your scheduled appointment so that we may schedule another patient for that time. DO NOT send cancellations through email nor to my cell phone. **Please call the** office where your appointment is scheduled. **If we are closed, please leave a message.** All business must function with this understanding.

ALEXANDRIA: 703-549-2626

A \$50 charge will be assessed for ALL NO SHOWS (un-cancelled appointments). Fees for un-cancelled appointments will be annotated to your individual invoice with payment expected before your consultation on your next visit. Please honor this policy to avoid unnecessary charges.

I have read the above and I understand that I will be charged \$50 if I fail to cancel my appointments. I also understand that this charge is in addition to any payments.

Signed

Date

Notice of Privacy Practice Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1966**

("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice.

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

If you feel your individuals rights, including the right to complain or if you believe your privacy rights have been violated, you may contact the HHS directly.

Patient Name _____
Print

Relationship to Patient: _____

Signature: _____

Date: _____

B-12 Shot Authorization

Because your carbohydrate intake will decrease while you lose weight, your energy level may decrease as well. Replenish your body's energy **naturally** with Vitamin B-12 injections. This important vitamin also helps boost your energy, metabolize fat and boost calcium absorption.

Please Fill Out Completely

Patient's Name: _____

Date of Birth: _____

Have you ever received a Vitamin B12 shot before? Yes___ No___

If you answered yes, did you have any adverse reaction? Please explain:

Allergies to Medication () Yes () No

If yes, which ones? _____

I have read the above and the benefits and risk of receiving vitamin B12 has been explained to me. In addition, I have been able to ask questions that were answered to my satisfaction. I hereby hold Dr. Heron's office harmless if I should have a reaction to the B12 shot. In conclusion, I hereby authorize Dr. Heron's office to give me this shot.

Patient's Signature

Date

Staff

Date

Heron Med Spa



Marketing Authorization and Use of Photographs

According to federal law we must ask for your permission to send to you via email, text, social media or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts, Open House invitations).

Our office DOES NOT SELL or SHARE our patient’s names or information.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and **I understand that my health care will not be affected if I do not sign this form.** I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing or email. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I DO _____ I DO NOT _____ Please select one

Authorize Heron Med Spa services or promotions the practice offers. You may choose email, cell phone or both.

I DO _____ I DO NOT _____ Please select one

Authorize Heron Med Spa to use my photographs.

Patient Signature

Date

Email Address Please Print

Cell Phone Number