**BMI**

**Bariatric & Metabolic Institute**

**DATE \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_\_ NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS #\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ SEX: MALE\_\_\_\_ FEMALE \_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ AGE\_\_\_\_\_ MARITAL STATUS: S\_\_\_\_ M\_\_\_\_ D \_\_\_\_ W\_\_\_\_ (PLEASE CHECK)**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYMENT INFORMATION:**

**EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXT\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT INFORMATION:**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SPOUSE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)**

**INTERNET FRIEND DRIVE BY RADIO DIRECT MAIL BROCHURE**

**Preferred Pharmacy: Name/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Clinic: Name/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL POLICY: Thank you for selecting BMI-Bariatric & Metabolic Institute for your health care needs. This is to inform you of our billing requirements and our financial policy. Please be advised that payments for services will be due at the time services are rendered, unless prior arrangement have been made. For your convenience we accept Master Card, Visa, American Express, checks and cash. We also accept Medicare.**

**I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all I have read and understand all the above and agree to these statements.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Patient Signature) (Date)**

**HIPAA Privacy Authorization Form**

**\*\*Authorization for Use or Disclosure of Protected Health Information**

**(Required by the Health Insurance Portability and Accountability Act, 45 C.F. R. Part 160 & 164)**

1. **\*\*AUTHORIZE\*\***

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize Vishnu Subramani M.D. (healthcare provider) to use and disclose the protected health information described below to primary care physician or other medical providers (individual seeking the information). \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient initials)**

1. **\*\*EFFECTIVE PERIOD\*\***
* **All past, present, and future periods. \_\_\_\_\_\_\_\_\_\_\_\_\_ (patient initials)**
1. **\*\*EXTENT OF AUTHORIZATION\*\***
* **I authorize the release of my complete health record to Vishnu Subramani M.D. and the Bariatric & Metabolic Institute.**

**This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.**

**I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person/entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used/disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal/state law.**

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**PATIENT MEDICAL HISTORY FORM**

**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**AGE:** \_\_\_\_\_\_\_\_**BIRTHDATE:**\_\_/\_\_\_/\_\_\_\_\_

1. **Are you in good health at the present time to the best of your knowledge? YES / NO**

**Explain “NO” answer:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you under a doctor’s care at the present time? YES / NO**

**If “YES”, for what?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently taking medication at this time? YES / NO**

**List All Prescription Medications and Over-the-Counter Medications, Vitamins**

 **MEDICATIONS DOSAGE AMT. FREQUENCY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you allergic to any medications? If so, please list YES / NO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **PERSONAL HEALTH HISTORY QUESTIONNAIRE** |
| **(Circle All That Apply)** |
| **EYES** | Glasses | Contacts | Glaucoma | Double Vision | Eye Disease |
| **EARS/NOSE/ THROAT** | Tinnitus (Ear Ringing) | Nose Bleeds | Hoarseness |   |   |
| **CARDIOVASCULAR**  | Chest Pain Heart Failure Murmur Vascular Disease | Fainting Lower Extremity Edema Coronary Artery Disease | Stroke Heart Disease Irregular Pulse (palpitations/flutter) | Rheumatic Fever | Blood Clots |
| **RESPIRATORY**  | Shortness of Breath | Asthma Bronchitis Pneumonia | Seasonal Allergies  | Hay Fever | Chronic Cough |
| **GASTROINTESTINAL** | Gallbladder Liver Disease | Gall Stones Stomach Ulcers | Diarrhea Constipation Bloody-Stools | Indigestion  | Nausea/Vomiting |
| **GENITOURINARY**  | Kidney/Bladder Disorder | BPH/Prostate Enlargement | Overactive Bladder |   |   |
| **OTHER** | Diabetes High Blood Pressure  | High Cholesterol | Sleep Apnea Fatigue | Thyroid Disease Anemia | Migraine/Head Ache |
| **MUSCULOSKELETAL** | Arthritis/Joint Issues | Osteoporosis | Back Pain |   |   |
| **PSYCH** | Anxiety | Depression | Memory Loss | Trouble Sleeping | Drug/Alcohol Abuse |
| **CANCER** | Breast | Ovarian | Prostate | Colon | Other \_\_\_\_\_\_\_\_\_ |
|   |   |   |   |   |   |

**SURGICAL HISTORY: (List Previous Surgeries)**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN: Gynecological History**

**Menstruation began age:** \_\_\_\_\_\_\_\_\_  **28-Day Cycle: YES / NO**

**Regular Periods: YES / NO**  **Painful Periods: YES / NO**

**MEN: GU History**

**Date of last Prostate/Rectal Exam** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has **force of urination decreased? YES / NO**

**Have you seen blood in urine? YES / NO Do you have problems emptying bladder? YES / NO**

**SOCIAL HISTORY:**

**Do you exercise? YES / NO If yes, how often? \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol: YES / NO If yes, how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nicotine Products: YES / NO If yes; type/ how often?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician (PCP) Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last physical exam:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY: Circle all that apply to anyone in your immediate family**

**High Blood Pressure Heart Disease Stroke Diabetes Atherosclerosis (hardening of arteries) Thyroid Disease High Cholesterol Osteoporosis/Bone Disease**

**Cancer: (Type)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**GENETIC & FAMILY HISTORY**

1. **What was your birth weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Were you full term at birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Were you breast fed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **What was your weight at 10 – 12 years of age? (Rough numbers) \_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **What was your weight at 13 – 18 years of age? (Rough Numbers) \_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **What was your weight in college? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **Please provide any additional timelines of weight after college. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
8. **How many siblings in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
9. **Did your siblings struggle with weight related issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
10. **Were your Parents overweight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WEIGHT LOSS PROGRAM QUESTIONNAIRE**

1. **When did you first become overweight?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How long have you been trying to lose weight?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_

1. **How did your weight gain start? Describe any** **circumstances:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Present Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Goal Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Circle all PROGRAMS you have tried in order to lose weight:**

**Weight Watchers Nutrisystem Jenny Craig Surgery (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Overeaters Anonymous OTC Diet Pills (Type)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever taken prescription weight loss medication (appetite suppressants)? YES / NO**

**If yes, name of program:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of appetite suppressant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you experience side effects? YES / NO: \_\_\_\_\_\_ If yes, describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check any of the dietary problem areas listed below that apply to you:**

**( ) Meal Skipping ( ) Carbohydrate Craving ( ) Large Portion Size**

**( ) Too Much Alcohol ( ) Eating foods too high in fat ( ) Frequent Snacking**

**( ) Eating out too much ( ) Eating before bed ( ) Eating when not**

**Hungry**

**Describe any typical day of eating from breakfast to dinner and any snacking in between:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**PHYSICIAN NOTES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of individual’s home.

**I WISH TO BE CONTACT IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)**

HOME TELEPHONE

* O.K. to send Text message for follow-up/accountability program (text message fees will apply)
* O.K. to leave message with detailed information
* Leave a message with call back number only

WRITTEN COMMUNICATION

* O.K. to mail to my home address
* O.K. to fax to this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient’s Signature)

I have received/reviewed both pages of HIPAA privacy practice notice and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy statement.

**BARIATRIC & METABOLIC INSTITUTE LLC**

**97 N. KINGSHIGHWAY SUITE 7 CAPE GIRARDEAU MO 63701**

**Please read carefully!**

**The Bariatric & Metabolic Institute otherwise known as BMI, its representatives, physicians, and/or directors do not guarantee weight loss results or the intended results of any of its programs.**

**BMI’s primary goal is to provide you, the prospective patient tools necessary to be successful in your weight loss journey losing weight and keep it off. All the programs designed by BMI serve only as a roadmap by which you, the patient need to follow in-order to be successful.**

**By signing below, you understand that weight loss is strictly a result driven by you the patient and BMI serves as the catalyst or service in-order for you to achieve that goal. You also understand that there is no “magic bullet” or medication that will allow you to automatically lose weight without you doing the work. BMI does not guarantee that you will lose weight without following the strict recommendations of BMI.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Date**



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| --- |
| **Stats Log** |
| **DATE** | **B/P** | **WEIGHT** |
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