### BUCKEYE PHYSICAL MEDICINE AND REHAB - GAHANNA WEIGHT LOSS PATIENT INTAKE

	<u>GEN</u>	IERAL INFORMAT	ION	
Name:			(Age) Gender	r: M F
Home Address:			Home Phone:	
City, State, Zip:			Work Phone:	
Email Address:			Cell Phone:	
Birth Date:/	_/ Social Security	#:	Marital Status: S	M D W
Drivers License Number and	State issued	State		
As a convenience to our patie	ents, we offer appointment re	minders through emails and to	ext messages. Would you like	to be set up on automatic
text reminders? [] Yes [	] No If yes, who is your cell	phone provider?		
carrier and myself. If this of convenience to me. The office	fice chooses to bill any service will provide any necessary	ccident, work related, or gene es to my insurance carrier tha reports or required information d that I am ultimately respons	at they are performing these so on to aid in insurance reimbur	ervices are strictly as a sement of services, but I
Signature of Patient	or Guardian of said N	linor		_ Date
		HEALTH HISTORY	<u>(</u>	
In what time frame would	you like to be at your desi	Max Lifetime We ared weight?		
What is the main reason for	or your decision to lose we	eight?		
When did you begin gaini	ng excess weight?			
Previous diets you have fo	ollowed, including dates, a	nd any results you received	d from weight loss attempt	s
Is your spouse, fiancée or	partner overweight?	Do you awaker	n hungry during the night?	
How often do you eat out	?	How often do you eat fa	ast food?	
Do you wake up hungry in	n the morning?	What time of day are	e you most hungry?	
On average, how many ho	ours of sleep do you get pe	r night?		
Who is your primary care	physician? (doctor and/or	practice)		
Please check to indicate if y	ou are currently experienci	ng any of the following cond	litions:	
<ul> <li>□ Neck Pain/Stiffness</li> <li>□ Back Pain/Stiffness</li> <li>□ Arm/Hand Pain</li> <li>□ Leg/Knee Pain</li> <li>□ Headaches</li> <li>□ Dizziness</li> <li>□ Asthma</li> </ul>	<ul> <li>□ Pins/Needles in Arms</li> <li>□ Pins/Needles in Legs</li> <li>□ Fatigue</li> <li>□ Sleeping Difficulties</li> <li>□ Loss of Smell</li> <li>□ Allergies</li> <li>□ Blurred Vision</li> </ul>	<ul> <li>□ Light Bothers Eyes</li> <li>□ Depression</li> <li>□ Nervousness</li> <li>□ Tension</li> <li>□ Cold Sweats</li> <li>□ Stomach Problems</li> <li>□ Night Pain</li> </ul>	□ Sudden Weight Loss □ Loss of Taste □ Loss of Memory □ Jaw Problems □ Constipation □ Shortness of Breath □ Bowel/Bladder Changes	<ul> <li>Nausea</li> <li>Cold Feet</li> <li>Chest Pain</li> <li>Fever</li> <li>Fainting</li> <li>Eczem</li> </ul>

→ Aids/HIV	Cataracts	Hernia	Pacemaker	Thyroid Problems
☐ Alcoholism	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
Allergy Shots	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anemia ☐ Anorexia	☐ Diabetes	<ul><li>☐ High Cholesterol</li><li>☐ Kidney Disease</li></ul>	<ul><li>□ Pneumonia</li><li>□ Polio</li></ul>	☐ Tumors/Growths
Anorexia Appendicitis	☐ Emphysema ☐ Epilepsy	Liver Disease	☐ Prostate Problems	☐ Typhoid Fever☐ Ulcers
Arthritis	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Asthma	☐ Glaucoma	■ Migraines	Psychiatric Care	Venereal Disease
☐ Bleeding Disorders	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Breast Lump ☐ Bronchitis	<ul><li>☐ Gonorrhea</li><li>☐ Gout</li></ul>	<ul><li>Mononucleosis</li><li>Multiple Sclerosis</li></ul>	<ul><li>☐ Rheumatic Fever</li><li>☐ Scarlet Fever</li></ul>	Other
Bulimia	☐ Heart Disease	☐ Mumps	☐ Stroke	
☐ Cancer	☐ Hepatitis	Osteoporosis	☐ Suicide Attempt	
Are you currently pregn	ant? □ Yes □ No			
Are you currently under	drug and/or medical care?	Yes □ No If yes, explain		
Please list any medication	ons you are currently taking (Be	sure to include dosage and f	requency)	
Please list any surgeries	and/or hospitalizations you hav			
		(51		
<u>-</u>	as your last prostate exam?		-	
	ents you are currently taking (vit			
Are you currently on an	y blood thinners – (aspirin regir	men included)? □ Yes □ N	o List Type	
Contraindications: A f	ew Procedures in the office sh	ould be avoided if patients	have certain conditions.	
Please CHECK if you h	ave any of the following: □ Ty	pe 2 Diabetes □ Sleep Apr	ea □ High Cholesterol □ A j	pacemaker
•			_	
☐ Suffer from blood clo	ots    Local or systemic infer	ction □ Allergies (please l	ist)	· 
☐ Suffer from blood clo	ts ☐ Local or systemic infection ☐ Glucontrolled Hypertension ☐ Gl	ction □ Allergies (please l laucoma □ Rapid Heartbea	ist) □ Severe Depression □ U	Incontrolled clotting disorder
☐ Suffer from blood clo ☐ Atria Fibulation ☐ U ☐ Renal Disease ☐P	ots ☐ Local or systemic infection ☐ Glucontrolled Hypertension ☐ Glucontrolled Hypertension ☐ Hi	ction □ Allergies (please l laucoma □ Rapid Heartbea istory of Stroke □ Hyperthy	ist)	Incontrolled clotting disorder whol Abuse
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □P Is there a family histor	ots □ Local or systemic infection □ Glucontrolled Hypertension □ Glucontrolled Hypertension □ Hiperty of any of the following conditions:	ction □ Allergies (please laucoma □ Rapid Heartbean istory of Stroke □ Hyperthy itions? (Indicate family men	ist)	Incontrolled clotting disorder bhol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □P: Is there a family histor □ Heart Disease	ots □ Local or systemic infection □ Controlled Hypertension □ Controlled Hypertension □ Hipertension □ Hipertension □ Hipertension □ Diagram □ Di	ction  Allergies (please laucoma  Rapid Heartbean istory of Stroke  Hyperthy itions? (Indicate family menuabetes	ist) Use a severe Depression Use Use Severe Depression Use	Incontrolled clotting disorder whol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ ■ Is there a family histor □ Heart Disease □ □ □ □ Cancer □ □	Local or systemic inferior of the following cond	ction  Allergies (please laucoma  Rapid Heartbean istory of Stroke  Hyperthy itions? (Indicate family menabetes  thritis	ist) Use the content of the co	Uncontrolled clotting disorder whol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ ■ Is there a family histor □ Heart Disease □ □ □ □ Cancer □ Do you exercise?: □ Ye	ots □ Local or systemic infection □ Glucontrolled Hypertension □ Glucontrolled Hypertension □ History of any of the following cond □ Di □ Artes □ No How often?: 1X	ction	ist)  Severe Depression	Incontrolled clotting disorder ohol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ ■ Is there a family histor □ Heart Disease □ □ □ □ Cancer □ Do you exercise?: □ Ye	Local or systemic inferior of the following cond	ction	ist)  Severe Depression	Incontrolled clotting disorder ohol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ Is there a family histor □ Heart Disease □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ots □ Local or systemic infection □ Glucontrolled Hypertension □ Glucontrolled Hypertension □ History of any of the following cond □ Di □ Artes □ No How often?: 1X	ction	ist) Coga	Incontrolled clotting disorder ohol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ Is there a family histor □ Heart Disease □ □ □ □ Cancer □ □ □ □ You exercise?: □ You work activities □ R	Local or systemic infersor Local Local or systemic infersor Local or systemic infersor Local Pregnant/Breast Feeding History of any of the following cond Local Lo	ction	ist) Coga	Incontrolled clotting disorder ohol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ Is there a family histor □ Heart Disease □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Local or systemic infection of the Incontrolled Hypertension of Glargenant/Breast Feeding of History of any of the following condition of the following condition of the following of the following of the following condition of the following of th	ction	ist) Comparison	Incontrolled clotting disorder ohol Abuse arents & siblings)
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ ■ Is there a family histor □ Heart Disease □ □ □ □ □ Cancer □ □ □ You exercise?: □ You work activities □ Do your work activities ■ Caffeine □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Local or systemic infection   Uncontrolled Hypertension   Glargenant/Breast Feeding   Hirty of any of the following cond   Diagram   Ares   No How often?: 1X   Unnning   Jogging   Weight   Mostly involve:   Sitting   dy intake of the following:   Ups/day Alcohol	ction	ist) Control   Cont	Incontrolled clotting disorder ohol Abuse arents & siblings)  ng □ Other packs/da
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ □ Is there a family histor □ Heart Disease □ □ □ □ □ Cancer □ □ □ Y Which activities: □ R Do your work activities What is your daily/week Caffeine □ □ □ □ I hereby certify that the	Local or systemic infection   Uncontrolled Hypertension   Glargenant/Breast Feeding   Hirty of any of the following cond   Diagram   Ares   No How often?: 1X   Unnning   Jogging   Weight   Mostly involve:   Sitting   dy intake of the following:   Ups/day Alcohol	ction	ist) Consider that providing incorrections are considered by the constant of the consta	Incontrolled clotting disorder ohol Abuse arents & siblings)  Ing
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ P. Is there a family histor □ Heart Disease □ □ You exercise?: □ You work activities: □ R Do your work activities: □ R Do your work activities: □ R Under □ □ □ You work activities What is your daily/week Caffeine □ □ □ C I hereby certify that the dangerous to my healther of the state of	Local or systemic infections and Local or systemic infection and Incontrolled Hypertension are Glargenant/Breast Feeding are Higher Higher Hardward	ction	ist)   Severe Depression   U   Proid   History of Drug/Alcomber including parents, grandp   Stroke   Other   Other   Other   Pilates   Swimming   Heavy Labor   Superior   Swimming   Cups/day   Cig   Cu	Incontrolled clotting disorder bhol Abuse arents & siblings)  Ing    Other packs/da arettes packs/da arettes packs/da aretinformation can be
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ P.  Is there a family histor □ Heart Disease □ □ □ Cancer □ Do you exercise?: □ You which activities: □ R Do your work activities What is your daily/week Caffeine □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Local or systemic inference of the following cond conditions of the following conditions conditions of the following conditions cond	ction	ist) series	Incontrolled clotting disorder ohol Abuse arents & siblings)  Other packs/da  It information can be
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ Is there a family histor □ Heart Disease □ □ Is Cancer □ Concer □ □ Is Which activities: □ Reduction in the control of the close of the control of the close o	Local or systemic inference of the following cond conditions of the following conditions conditions of the following conditions cond	ction	ist) series	Incontrolled clotting disorder phol Abuse arents & siblings)  ng □ Other packs/date information can be
□ Suffer from blood clo □ Atria Fibulation □ U □ Renal Disease □ □ P. (is there a family histor □ Heart Disease □ □ P. (is there a family histor □ Heart Disease □ □ P. (is there a family histor □ Heart Disease □ □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □ P. (is there a family histor □ Cancer □	Local or systemic inference of the following cond conditions of the following conditions conditions of the following conditions cond	ction	ist) series	Incontrolled clotting disorder ohol Abuse arents & siblings)  Other packs/date information can be

#### **AUTHORIZATION OF CARE**

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible	e for guaranteeing payme	ent for all services)	
This assignment will remain in effect until as the original. I have read and fully unders		ing. A photocopy of this assignment is to	be considered as valid
Patient's Name Printed	Date	Patient's signature	Date
Minors Name  I hereby authorize Buckeye Physical Medicine and Re	•	Signature of Authorizing care for minor or care as deemed necessary to my child, a minor un	Date der the age of 18 years old.
	EMERGENC	Y CONTACT	
Name	W	ork Phone	
Relationship	Но	ome Phone	
Cell Phone			

# NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT (CONSENT TO USE PHI)

#### Acknowledgement for Consent to Use and Disclosure of Protected Health Information

#### Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Buckeye Physical Medicine and Rehab - Gahanna or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

#### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

#### Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

#### By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time of Day
Witness Signature	Date

## **WLP Consent Form**

I,, authorize Buckeye Physical Medicine and Rehab –
Gahanna and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques and may involve the use of appetite suppressant medications. Other treatment options may include a low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.
I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.
I understand that much of the success of the program will depend on my efforts that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. 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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.
If you have any questions regarding the risks and hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.
Please note: Signing this form in no way obligates you to participate in the program.
Patient's SignatureDate

### **Financial Consent Policy Form**

rmancial Consent I oncy Form
Thank you for selecting Buckeye Physical Medicine and Rehab - Gahanna for your health care needs.
We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.
I,, agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I understand that all products are non-refundable and cannot be returned to Buckeye Physical Medicine and Rehab.
I have read and understand all of the above and have agreed to these statements.
All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.
Patient Signature Date