Virginia Weight & Wellness
4439 Cox Road | Glen Allen, Virginia 23060
804-726-1500 | Fax: 804-726-1501 | www.VirginiaWeightLoss.com

WELCOME TO VIRGINIA WEIGHT & WELLNESS

Thank you for choosing Virginia Weight & Wellness for your weight management needs. We sincerely look forward to meeting you and working together to help you achieve your goals.

Our office address is **4439 Cox Road, Glen Allen, Virginia 23060** and we are located in the West End of Richmond, in the Innsbrook area. Our office is at the intersection and stoplight at Cox Road and Waterfront Drive in the office park called Vantage Place. Once inside the Vantage Place office complex, our office is located on the corner immediately to the left. Parking is available directly in front of the office.

Please visit **www.VirginiaWeightLoss.com** for complete driving directions and details about our medical practice.

Here are a few things to know and have prepared for your first visit:

1) **New Patient Forms.** Please fill out the complete paperwork and forms in advance of your visit. It is **10 pages** and includes your medical history, weight history, consent forms, and a copy our "Privacy Policy" for your records. **We understand and appreciate that the forms and questionnaires are very detailed and will take about 20 minutes to complete. Please take the time to fill them out completely and accurately as this really helps us learn more about you so that we can better assist you during your visits.**

   If you can, **please fax your new patient forms to our office 3-7 days prior to your visit** as this will allow us time to transfer your information into our electronic medical record and allow us to review your chart prior to your visit. You may fax your paperwork to **fax number (804) 726-1501**.

2) **Medication List.** If you have not already filled out the paperwork prior to your visit, please make sure to bring a complete list of all of your medications and their doses so that we may accurately record them in our chart.

3) **Labs.** If you have had blood work drawn in the last 6 months, please bring a copy to your 1st visit, or arrange a copy to be faxed to our office. If not, **we can draw fasting labs in our office at your visit (if you are fasting)**, **or** we can give you a lab slip which you can take at your convenience to **any Labcorp site** throughout the Greater Richmond area as well. Labs drawn at Labcorp are billed by Labcorp through your insurance.

4) **EKG.** If you are considering the use of an appetite suppressant, we request that you have an EKG done within the last 90 days. If you have not had an EKG performed during the last 90 days, then we will perform one during your visit. If you have had an EKG within the last 90 days, please obtain or arrange a copy to be faxed to our office at (804) 726-1501.

5) **Payment.** Please note that full payment is required at the time of service. Your new patient visit with Dr. Sicat is $200 (or $150 with Kelly Steiner, ANP or Erin Poston, PA-C) and our office accepts cash, credit cards (Visa & MasterCard) and checks.

6) **Please arrive 20 min prior to your scheduled appointment** so we can register you and start your visit on time.

7) **Fax New Patient Forms**. Again, if possible, please fax your completed New Patient Forms to **(804) 726-1501** in advance of your scheduled appointment.

Thank you and we look forward to meeting you!

Sincerely,

Jeffrey Sicat, MD ~ Kelly Steiner, ANP ~ Erin Poston, PA-C and The Staff of Virginia Weight & Wellness

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New Patient Demographic Info

Patient Information	**Please Print all Information Clearly with a Black Pen**
Title	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
First, Middle, and Last Name	
Preferred / nickname if different from above	
Address Line 1	
Address Line 2	
City, State, Zip Code	
Phone Number(s) please star (*) your preferred phone number	Home ( )
	Cell ( )
	Work ( )
Okay to leave a message on home phone?	**no yes** Okay to leave a message on cell phone? **no yes**
E-mail address (only if we may email you)	
by writing your email above, you authorize us to email you an appt reminder 7 days and 2 days prior to your appt	
Birthday (mm/dd/yyyy)	Age:
Social Security # (optional)	
Your Occupation and Employer Name	**Your occupation:**
Marital Status (& spouse name)	
Spouse's Occupation and Employer Name	Spouse:
Primary Care Provider's Name	PCP:
Names of your other Physicians	Your other doctors:
How did you hear about us?	
Pharmacy Information	
Pharmacy Name	
Pharmacy Phone Number	
Pharmacy Street Address (or street name)	
Pharmacy City / Town	
Emergency Contact Information	
First and Last Name and Relationship	
Phone Number(s)	
Authorization to Release Healthcare Information	
Please list below the people that you authorize us to discuss your healthcare and health conditions with? (optional)	
Name, Relationship, and Phone #	
Name, Relationship, and Phone #	
Name, Relationship, and Phone #	

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New Patient Medical History

Medications	
List all prescription medications & doses below	**List all Over-The-Counter and Dietary Supplements**
☐ check here for "no prescription medications"	☐ check here for "no OTC meds or dietary supplements"
please include method of birth control (i.e. OCPs or IUD)	

Allergies to Medications (list drug name and allergic reaction below)	
☐ check here for "no allergies"	

Medical Conditions and Surgeries			
Do have a history of any of the following conditions?			**List any OTHER MEDICAL CONDITIONS below:**
High Blood Pressure	**no**	**yes**	
High Cholesterol	**no**	**yes**	
Diabetes	**no**	**yes**	
Personal history of Heart Disease	**no**	**yes**	
Previous heart attack or stent?	**no**	**yes**	
Previous heart surgery (bypass?)	**no**	**yes**	
Stroke / TIA	**no**	**yes**	
PCOS (polycystic ovary syndrome)	**no**	**yes**	
Low Thyroid (Hypothyroidism)	**no**	**yes**	
Migraine Headaches	**no**	**yes**	**List any previous SURGERIES below:**
Sleep Apnea	**no**	**yes**	☐ check here for "no previous surgeries"
If so do you use a CPAP machine?	**no**	**yes**	
Depression	**no**	**yes**	
Anxiety	**no**	**yes**	
Asthma / Emphysema / COPD	**no**	**yes**	
Eating Disorder (anorexia / bulimia)	**no**	**yes**	
Glaucoma	**no**	**yes**	

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Social History						
Marital Status (please circle)	Single	Married	Engaged	Partnered	Divorced	Widowed
Who lives in the Household with you?	Live with:					
Your Children's Ages & Names: (if applic)	Children:					
Employment or Work Status	☐ Working as (Occupation/Employer):					
	☐ Homemaker					
	☐ Student at:					
Smoking History	☐ I've never smoked					
	☐ I previously smoked but quit					
	☐ I currently smoke the following # of packs per day:					
Alcohol Use	☐ I do not drink any alcohol					
	☐ I previously drank but quit	History of alcoholism?	**no**	**yes**		
	☐ I currently drink alcohol. How many drinks per week?					
Drugs / Illicit Substances	Have you ever given yourself street drugs with a needle?		**no**	**yes**		
	Do you have a history of any drug addition?		**no**	**yes**		
	Are you currently using any street/illicit drugs?		**no**	**yes**		
Sexual / Reproductive History	Are you sexually active?		**no**	**yes**		
	If yes, are you currently trying to become pregnant?		**no**	**yes**		
	If not trying to conceive, what contraceptive method?					
	Is there a possibility that you are pregnant right now?		**no**	**yes**		
	Do you have a history of infertility?		**no**	**yes**		
	When was your last menstrual cycle?					
	How many menstrual cycles do you have per year?					

Family History (list family members below with each of the following conditions)	
Indicate who in your family have any of the following medical conditions: (e.g. mother, father, brother, sister, children, cousins, uncles, aunts, grandparents)	Cancer (list types):
	Diabetes:
	Heart Disease:
	High Blood Pressure:
	High Cholesterol:
	Hypothyroidism/Low Thyroid:
	Sudden Death (age < 40):
	Other Family Conditions:

Review of Systems (please circle if you have any of the following)				
General	→	Fatigue	Always Cold	Always Hot
Heart	→	Chest Pain	Palpitations	Leg Swelling
Lungs	→	Shortness of Breath	Coughing	Wheezing
Abdomen	→	Nausea / Vomiting	Constipation	Diarrhea
Menstrual	→	Irregular Cycles	No Menstrual Cycles	Post-Menopausal
Mental Health	→	Depression	Anxiety	Trouble Sleeping
Skin	→	Hair Loss	Acne	Extra Facial Hair
Neurological	→	Headaches	Numbness/Tingling	Tremors

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Weight History				
Current Height	Current weight	Lowest adult weight what year?	Highest weight what year?	Goal weight
How much Weight (lbs) have you gained over the following most recent time periods?				
6 months	1 year	2 years	5 years	10 years

What is the main reason why you are seeking to lose weight?

When did you start gaining extra weight (please provide possible reasons for weight gain if known)?

What do you think is the main cause of your weight gain?

List previous weight loss programs and previous diets you have attempted (include dates and results):

What do you think is the most effective way for you to lose weight?

What do you think your biggest obstacle is that has prevented or might prevent you from losing weight?

Have you ever used any over the counter or prescription medications for weight loss (include names, dates, results)?

Have you had labs drawn in the last year?	☐ No	☐ Yes - approximately what month?
Interested in using <u>all</u> meal replacements?	☐ No	☐ Yes, I'd like to use bars/shakes to replace <u>ALL</u> my meals
Interested in using <u>some</u> meal replacements?	☐ No	☐ Yes, I'd like to use bars/shakes to replace <u>SOME</u> meals
Have you previously had bariatric surgery?	☐ No	☐ Yes, I previously had weight loss surgery
Do you plan on having bariatric surgery?	☐ No	☐ Yes, I plan on having surgery with Dr.

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Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)					
Meal	**Main Dishes**	**Side dishes**	**Desserts**	**Drinks**	**Eating Out / Restaurants**
Breakfast					# breakfasts out/week & where?
Morning Snacks					
Lunch					# lunches out/week & where?
Afternoon Snacks					
Dinner					# dinners out/week & where?
Evening Snacks					

How many breakfasts do you skip per week?	Why?	
How many lunches do you skip per week?	Why?	
How many dinners do you skip per week?	Why?	
How many meals per week do you eat out or take out (Including breakfast, lunch, and dinner)?		
Which restaurants do you usually eat out or take out at?		
Do you frequently eat overnight?	☐ No	☐ Yes, I eat overnight
Do you consider yourself a stress eater?	☐ No	☐ Yes, I eat when I'm stressed
Do you feel hungry all the time?	☐ No	☐ Yes, I'm always hungry
Are you interested in using an appetite suppressant?	☐ No	☐ Yes, I'm interested in an appetite suppressant
If so, we require an EKG within the last 90 days based on the Virginia Board of Medicine Guidelines		
Do you need an EKG? (we'll perform as part of your visit)	☐ No	☐ Yes, I need an EKG
Have you had previous heart testing? (stress test, echo?)	☐ No	☐ Yes, I've had previous heart testing

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Activity and Exercise	
Please select your current activity level (select only one of the options)	☐ Inactive - no regular physical activity with a sit down sedentary job ☐ Moderate Activity - i.e. occasionally walk, jog, run, bike, golf, tennis ☐ Heavy Activity - regular exercise at least 3x per week ☐ Vigorous Activity - extensive exercise > 60 min at least 4x/week
Outside of work and working in the home, please describe what physical activity you do and how often:	
Do you do any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)?	
What limits or prevents you from participating in more physical activity or exercise (e.g. joint problems, arthritis, time)?	
Do you have membership at any gyms or exercise facilities? Which one(s)?	

Behavior Styles, Stress, and Sleep Hygiene	
Behavior Style (select only one of the options)	☐ You are calm and easygoing ☐ You are sometimes calm but frequently impatient ☐ You are seldom calm and have overwhelming drive for ambition ☐ You are hard driving and can never relax
Please circle your **STRESS** level:	**0 1 2 3 4 5 6 7 8 9 10** 0=no stress 5=moderate stress 10=extreme stress
Please describe major sources of stress in your life and how they affect you:	
Sleep Hygiene and Sleep Patterns (select all that apply)	* What time do you usually go to sleep? * What time do you usually wake up? * Do you wake up through the night? ☐ no ☐ yes * Do you wake up and eat overnight? ☐ no ☐ yes ☐ I usually sleep 8 or more hours per night ☐ I usually sleep 6 - 8 hours per night ☐ I usually sleep 4 - 6 hours per night ☐ I usually sleep < 4 hours per night ☐ I snore heavily at night ☐ I wake up in the morning still tired ☐ Have you ever had a sleep study? ☐ no ☐ yes ☐ I have sleep apnea; if yes do you use CPAP? ☐ no ☐ yes ☐ I work and live a night schedule and sleep during the day

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PATIENT INFORMED CONSENT FOR THE USE OF APPETITE SUPPRESSANTS

I. Procedures and Alternatives

1. I authorize Virginia Weight and Wellness to assist me in my weight loss efforts. I understand that my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks, and when indicated, in higher doses than the dose in the appetite suppressant Food and Drug Administration (FDA) labeling.

   I understand that the use of appetite suppressants may be contraindicated with certain medical histories or certain medications. I agree that I will be completely honest in disclosing this information and will notify my health care provider of changes to my medical history or new medication use. I understand that failure to do so can be dangerous to my health.

   I understand that the use of appetite suppressants is completely voluntary and is not required to be used during my weight reduction program at Virginia Weight and Wellness.

2. I have read and understand my healthcare provider's statements that follow:

   "*Medications, including appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on the shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."*

   "In the field of weight loss medicine, appetite suppressants have been found helpful for periods exceeding 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician / healthcare provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, and studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

   "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

   "I believe the probability of such side effects may be outweighed in certain individuals, by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of the side effects, even if they might be serious, for the possible help the appetite suppressants being used in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I agree to take the medication only as prescribed by Virginia Weight and Wellness. I understand that taking medications in any way other than prescribed can be dangerous to my health. I agree that I will not resell the medication, nor ever share it with a family member or friend whatsoever. I agree that I will not visit another doctor for the purpose of obtaining additional or duplicate medication of the same type.

5. I agree to arrange for prescription refills for scheduled medications from Virginia Weight and Wellness only during regular clinic hours as some appetite suppressants are classified as controlled substances and are regulated by the Drug Enforcement Agency. I understand that controlled medications are not refilled in advance of the time of refill. Medications are typically refilled in one month increments and only via physician or provider during appointments with appropriate evaluation. I understand that missing my appointment may mean being out of the medications for a short period of time as controlled medications are not refilled via phone. I understand that Virginia Weight and Wellness is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

6. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on progress in weight reduction and weight maintenance.

7. I understand that medication prescriptions can be filled at Virginia Weight and Wellness or another pharmacy of my choice. If I use a pharmacy other than Virginia Weight and Wellness, I agree to use only one pharmacy to fill any weight loss scheduled prescriptions and I give my permission for Virginia Weight and Wellness to notify area pharmacies of the terms of this agreement.

8. I understand there are other methods and programs that can assist me in decreasing my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or and exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in doses higher than indicated on the labeling involves some risks. The more common nervousness, sleeplessness, headaches, dry mouth, weakness, psychological problems, medication allergies, high blood pressure, increased heart rate, and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks of Being Obese or Overweight

I am aware that there are certain risks associated with remaining overweight or obese. Among them are increased risk for high blood pressure, cholesterol, diabetes, heart disease, and joint pain and arthritis. I understand these risks may be modest if I am not very much overweight but that these risks increase the more overweight I am.

IV. No Guarantees

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent

I have read and fully understand this consent form and I realize I should not sign this form if I have any unanswered questions or concerns that have not been answered to my complete satisfaction. I have taken all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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WEIGHT-LOSS CONSUMER BILL OF RIGHTS:

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week, or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long term weight loss. Qualifications of this provider are available upon request. patient is under no obligation whatsoever, to purchase medication and/or supplements from Virginia Weight and Wellness.

You as the patient have the right to:

Ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated of the program; know the name, address, qualifications of the physician or provider who has reviewed and approved weight-loss program.

I have read and understand the above:

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF APPETITE SUPPRESSANT REFILL POLICY:

I agree to arrange for prescription refills for scheduled medications from Virginia Weight and Wellness only during regular clinic hours as some appetite suppressants are classified as controlled substances and are regulated by the Drug Enforcement Agency (DEA). I understand that controlled medications are not refilled in advance of the time of refill. Medications are typically dispensed only in one month increments and only via physician or provider approval during appointments with appropriate evaluation. I understand that missing my appointment may mean being out of the medications for a short period of time as controlled medications are not refilled via phone. I understand that Virginia replace any medications or prescriptions that

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" (HIPAA):

By signing this form, I acknowledge that I have received a copy of the "Notice of Privacy Practices" of Virginia Weight and Wellness, which explains how your health information will be handled in various situations.

PATIENT SIGNATURE: _____

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NOTICE OF PRIVACY PRACTICES (KEEP THIS PAGE FOR YOUR FILES): THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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 of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

Treatment
We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used as needed to obtain payment for your health care services.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other uses of Medical Information:
In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:
In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:
You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

To request this list of disclosures, indicate the relevant period, which must be after July 1, 2011. You must submit your request in writing to the Privacy Office listed below.

Right to Request Restrictions:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to the Privacy Office listed below.

Requests for Confidential Communications:
You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:
You may receive a paper copy of this Notice from us upon request.

Changes to this Notice:
We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas. You can receive a copy of the current notice at any time. The effective date is listed at the end. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Office listed below or the Secretary of Health and Human Services. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office
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Glen Allen, Virginia 23060
(804) 726-1500

Updated July 28, 2014

