Carolina GI Associates, PC

Registration for Weight Loss Program

Name:_____

Phone No.: Home_____ Work_____Cell_____

Mailing Address:_____

City:_____State:_____Zip Code:_____

E-Mail Address:_____

Date of Birth:_____Social Security #:_____

Advanced Beneficiary Notice of Non-Coverage (ABN)

Unfortunately, most insurance companies do not cover weight loss services. If weight loss benefits are not available, I agree to pay the policy of payment at time of service. If benefits are available, I hereby authorize Carolina GI Associates, PC to apply for benefits on my behalf for covered services rendered and agree to pay my portion at tie of service. I certify the information I have reported with regard to my insurance coverage is correct and I request payment from my insurance company to be paid directly to Carolina GI Associates, PC.

I permit a copy of this authorization to be used in place of the original. My insurance company or I may revoke this authorization at any time in writing.

Date:_____ Signature:_____

**** Weight loss packages are non-refundable and visits must be used within 90 days of purchase.**

Weight Loss Program

To ensure a safe weight loss program, please answer the following health questions.

Do you have any of the following problems? If so please check:

_____ Pregnancy or Breastfeeding
Last menstrual cycle _____

_____ Pacemaker

_____ Defibrillator

_____ Hypertension/High Blood Pressure

_____ Heart Disease

_____ Cancer

_____ Glaucoma

_____ History of Stroke/TIA/Heart Attack

_____ Kidney/Liver Disease

_____ Thyroid Disorder

_____ History of eating disorder

_____ History of depression

_____ Current/Past drug addiction

_____ History of suicide attempt

_____ Unable to exercise

_____ Breathing Problems/COPD/
Bronchitis/Asthma/Lung Disease

Are you under the care of a physician for a medical problem?_____

List any previous surgeries:_____

Allergies:_____

What diets have your tried in the past?_____

How much weight did you lose?_____ What is your goal weight?_____

What didn't work for you in the past and why?_____

Why do you think you're overweight now?

Lack of time Overeating Slow metabolism Medical problems

Stress Lack of exercise Illness/injury

Do you exercise and how often?_____

What questions do you have?_____

_____

_____

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120 Charles D. Rollins Road
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Henderson, North Carolina 27536
Phone: (252) 430-8111
Fax: (252) 430-1804

Medication:	Strength:	How often is medication taken?

_____ _____

Patient's Signature (or authorized representative) **Date**

_____

Patient's Account Number