Medical Weight Loss Specialists

*Spencer Berry, MD Medical Director*

3175 Sienna Dr. S  Suite 103
Fargo, ND 58104

Phone: 701-205-3088
Fax: 701-335-7808
www.fargomedicalweightloss.com

Thank you for choosing Medical Weight Loss Specialists to help you with your weight management needs. We really look forward to meeting you.

Our address is **3175 Sienna Drive S, Suite 103, Fargo, ND  58104** off 32nd Ave S between 42nd St and 45th St. Please visit our website at: www.fargomedicalweightloss.com for driving directions, great information on what you can expect, and answers to the most commonly asked questions.

Here are a few things you should know and have ready for this first appointment:

**1) Be prepared to have your labs drawn** the day of your appointment. If you have a **copy of blood lab results done within the last three months**, please bring a copy to the office for your first appointment for evaluation and/or comparison. Do not eat or drink anything other than water or black coffee 8 hours prior to the appointment so we can draw "**fasting**" lab work. Non fasting labs may need to be repeated if significantly abnormal. If you are unable to fast before your appointment (due to an afternoon appointment or otherwise), please call the clinic prior to your appointment so that we may set up a lab draw appointment for you. This appointment only takes 5 minutes. In either case**, Please drink a minimum of 4 glasses of water prior to your lab appointment** so that you are fully **hydrated, which will make it easier to obtain your blood.**

2) **Please do not wear any type of lotion** or oil to this appointment in preparation for your **EKG.** If you had one done in the past 3 months, please **bring a copy of it**, but remember to still not wear the lotion in case it needs to be repeated.

3) Bring a **list of all medications and dosages with you.**

4) **Do not wear body suits, spanx, girdles or clothing that constricts tightly.** These clothing articles can affect the accuracy of your measurements and/or weighing process.

5) Remember that **payment is required on the day of service**. While we strive to be accurate in preliminary cost information, variances can occur as a result of your visit.

6) Due to having blood pressure taken and blood drawn, please wear **short sleeves and a loose top.**

7) There are patient forms that will need to be filled out at your initial visit. If you would like to fill them out beforehand, you may go to our website www.fargomedicalweightloss.com, download them, and bring them with you.

**Please allow approximately three hours for this first appointment.** Because of the length of time you will be here, please do not bring small children to this appointment.

## Please let us know at least 48 hours in advance if you need to cancel or reschedule your appointment.

We look forward to meeting you and helping you to achieve your weight management goals.

Spencer D Berry, MD and the Staff at Medical Weight Loss Specialists

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# New Patient History (*Please **PRINT** All information clearly)* *Date:___/___/___*

Name_____ Date of Birth____/____/_____ Age ____
Your address_____City/State_____Zip_____
Social Security#: _____/_____/_____ Are you on Medicare?_____
☐Home phone: ( )_____-_____☐Work: ( )____- _____☐Cell: ( )_____-_____
***Please indicate which phone number you would like for us to use as your primary number.***
***Email address:***_____ ☐***would you like email reminders***
Primary Physician_____PCP Phone # _____
Preferred Pharmacy: _____ Pharmacy phone:_____
Occupation:_____ Employer name _____
Shifts worked: (Day/PM/Night)_____

**Childproof medication bottle needed?** ☐Yes ☐No **If no, sign here**:_____

Height_____
Current Weight_____
Lifetime Heaviest weight (non pregnant)_____ Age at Heaviest Weight_____
Goal Weight_____ Age last at Goal weight_____
Have you ever had bulimia, anorexia or Binge eating disorder? _____

Do you Smoke? ____ If yes how much/day? _____ How many years have you smoked? ____
How many alcoholic beverages do you consume in a week? _____

**WOMEN**:
Are you Pregnant?_____ Are you Breastfeeding?_____
Are you menopausal or premenopausal? _____

## MEDICAL HISTORY:

Have you had any serious illness in the past that has led to hospitalization?
_____
Have you had any surgeries? _____
_____

**Please circle if you have been having any of the following symptoms**

| | | | |
|---|---|---|---|
| 1) Weakness | 8) Thick tongue | 15) Swollen feet | 22) Swelling of face & eyelids |
| 2) Dry, Coarse skin | 9) Coarse hair | 16) Hoarseness | 23) Excessive/painful menses |
| 3) Tired/fatigue | 10) Pale skin | 17) Loss of appetite | 24) Emotional Instability |
| 4) Slow speech | 11) Constipation | 18) Poor memory | 25) Depression |
| 5) Slow movement | 12) Gain in weight | 19) Nervousness | 26) Headaches |
| 6) Coldness and cold skin | 13) Loss of hair | 20) Heart palpitations | |
| 7) Diminished sweating | 14) Difficulty breathing | 21) Brittle nails | |

☐ **Please check here if none of the above 26 symptoms apply to you**

**Please check the medical conditions that YOU have been diagnosed with in the past or currently.**

- ☐ Past or current drug or alcohol problems
- ☐ Depression or anxiety
- ☐ Diabetes: Type 1(juvenile) or 2(adult)?
- ☐ Gestational Diabetes
- ☐ Insulin Resistance/Prediabetes/BorderlineDiabetes/Dysmetabolic Syndrome
- ☐ Polycystic Ovarian Syndrome
- ☐ Heart Burn
- ☐ Glaucoma (Open or Narrow Angle?)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack/Heart Failure
- ☐ Arrhythmia
- ☐ Heart Valve Problems/ Heart Murmurs
- ☐ Do you have a pacemaker: yes or no
- ☐ Do you have a defibrillator: yes or no
- ☐ History of passing out (syncope)
- ☐ Asthma
- ☐ Other Lung diseases (Type:_____)
- ☐ ADHD (Attention deficit disorder)
- ☐ Bipolarism or other psychiatric conditions? _____
- ☐ Kidney Diseases (Type:_____)
- ☐ Liver Diseases (Type:_____)
- ☐ Obstructive sleep apnea (use a CPAP?)
- ☐ Insomnia/ other sleep disorders
- ☐ Thyroid Disorders (Low or High or Other:_____)
- ☐ Other Chronic Medical Conditions:_____

Do you have any known Drug allergies? If yes please explain:

_____ _____

| **Current meds and doses**: | **Taking it for**? | **Over the counter meds/vitamins/herbals** |
|---|---|---|
| 1) _____ | _____ | 1) _____ |
| 2) _____ | _____ | 2) _____ |
| 3) _____ | _____ | 3) _____ |
| 4) _____ | _____ | 4) _____ |
| 5) _____ | _____ | 5) _____ |
| 6) _____ | _____ | 6) _____ |
| 7) _____ | _____ | 7) _____ |
| 8) _____ | _____ | 8) _____ |
| 9) _____ | _____ | 9) _____ |
| 10) _____ | _____ | 10) _____ |

**WHO** in your **FAMILY** has had the following? (mom, dad, siblings, aunts/uncles, cousins, grandparents)

- Heart disease/Heart Attack/Congestive Heart Failure _____
- Cancer (list type) _____
- High Cholesterol _____
- Sudden death < age 40 from a
- medical condition_____
- Diabetes or ñborderline diabetesò_____
- Mental illness (depression, bipolar, etc.) _____
- Who in family struggles with weight? _____
- Other family medical conditions _____
- Hypothyroidism _____
- High Blood Pressure _____
- Strokes _____

## Exercise

| *frequency*? | What is the *intensity*? | For *how long*? |
|---|---|---|
| ☐ None | ☐ None | ☐ None |
| ☐ 1-2x/week | ☐ Light (brisk walking, golfing, doubles tennis) | ☐ Under 10 minutes |
| ☐ 3-5x/week | ☐ Moderate (biking, low impact aerobics) | ☐ 10-20 minutes |
| ☐ Daily | ☐ Moderately hard (running, aerobics, hockey) | ☐ 20-30 minutes |
| | ☐ Very hard (Sprinting, speed swimming) | ☐ over 30 minutes |

Do you have any physical restrictions to exercise? (what are they)_____
Do you make yourself sick because you feel uncomfortably full? Y or N
Do you worry you have lost control over how much you eat? Y or N
Have you recently lost more than 15 pounds in a three-month period? Y or N
Do you believe yourself to be fat when others say you are too thin? Y or N
Would you say that food dominates your life? Y or N

What weight-loss programs have you tried in the past? _____
_____
Did they work? Why or why not?_____

**What do you hope to accomplish by being here?_____**
**_____**

**Lifestyle challenges:** Which of the following seem to sabotage your weight loss efforts:

| | | |
|---|---|---|
| Lack of time for planning & self | Eating late/waking up eating | Eating too fast |
| Comfort/stress eating | Liquid calories such as alcohol | Always hungry |
| Enjoyment of food | Specific food cravings like carbohydrates | Boredom eating |
| Social Events | Mindless eating/Habit | Other: |

**HOW DID YOU HEAR ABOUT THE CLINIC?**
**Radio** (Which station?)_____ **Magazine** (Which one?) _____
**TV Station** (Which one?) _____ Commercial --or-- Interview _____
**My doctor's office referred me to you. Dr or PA name: _____**
**Yellow Pages** (Which book?)_____ **Newspaper Ad** (Which section?) _____
**Internet:** Google ___ Yahoo ___ I typed in your website ___ Other?_____
**Mailer to the house**_____ **Bulletin** (Which one?)_____
**My family member, friend or co-worker** who is currently a patient here inspired me to start. *Please share who this was so we can say thank you to them. Their name please:*_____
**Other**_____

## Informed Consent for Treatment

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the medicines and length of medicine usage may be used in an "off label" manner. This means the doctor may be using the medicines in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine.

### Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us better help you.
2. Devote the **time and effort** necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal physician if necessary.
4. Make and keep **follow-up appointments** and allow necessary blood tests as needed.
5. Advise the clinic staff and Dr. Berry of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a personal physician before beginning this program.

### Possible Side Effects

1. **Reduced weight.** By reducing your caloric intake you may see a variety of **temporary and reversible** side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and, very rarely, a racing or pounding heart rate or an elevation in blood pressure or other more rare side effect. This will be closely monitored as safety is our number one priority.
2. **Reduced potassium levels or other electrolyte abnormalities.** We monitor electrolyte levels and correct them if they become too low. If they are not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.
3. **Gallstones.** Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gall bladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.
4. **Pancreatitis**. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs. You should take precautions to avoid becoming pregnant during weight loss.
6. **Sudden death**. Patients with obesity, especially those with associated high blood pressure, diabetes, heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.
7. **Risk of weight regain.** Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless they get in some type of maintenance program and long-term efforts at controlling the weight are continued. We will provide you with a maintenance plan and plan to help prevent weight regain.

**MEDICARE:**

**I am aware and understand that MWLS is NOT a Medicare Provider**

_____ _____

Patient Signature Date

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# RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.

1. Many weight loss medications are considered "controlled medications." By law, a controlled medication can only be received from one facility at the same time. I agree that only Medical Weight Loss Specialists (MWLS) will prescribe scheduled weight loss medications for me. I agree that it is my responsibility to inform my doctor and any other doctors from whom I receive treatment of this contract, and that it is my responsibility to inform any and all doctors from whom I receive treatment if I am prescribed and/or taking any scheduled medications. Medical Weight Loss Specialists may also notify my other doctors of the terms of this contract.

2. I understand that the use of weight loss medications is contraindicated with certain medical histories, or other medication use. I agree that I will be completely honest in disclosing this information & will notify my MWLS physician of changes to my medical history or new medication usage. I understand that failure to do so can be dangerous to my health.

3. I agree to take the medication only as prescribed by MWLS. I understand that taking medications in any way other than prescribed may be dangerous to my health.

4. I agree to arrange for prescription refills for scheduled medications from MWLS only during regular clinic hours. I understand that controlled medications are not refilled in advance to time of refill. Medications are typically dispensed only in one month increments and only via physician approval during physician appointment with appropriate vital signs. I understand that missing my appointment may mean being out of the medications for a small time period as controlled medications are not refilled via phone. I understand that MWLS is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

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

6. My signature placed on this contract indicates that I fully understand each statement and have had the opportunity to ask any questions pertaining to this.

Patient name (print) _____ Date _____

Patient signature _____
Witness signature_____Witness name (print)_____

## Your Rights and Confidentiality

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

**Please note that our Physicians do not take calls outside Medical Weight Loss Specialists' office hours. If you feel you are experiencing a medical emergency at any time, go to the nearest emergency room immediately for treatment**.

(HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION

**Uses and Disclosures of Information that We May Make Without Written Authorization:** For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody.

**Uses and Disclosures of Information That We May Make Unless You Object:** We may use and disclose protected health information in the following instances without your written authorization unless you object:

If you object, please notify the Privacy Contact identified at the end of this document.

**Persons Involved in Your Health Care:** Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that personôs involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

**Notification:** Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Person(s) Authorized to Receive Information _____

Physician Office(s) Authorized to Receive Medical Information_____

**Your Right Concerning Your Protected Health Information:** You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

**Entities to Whom This Notice Applies:** This notice applies to Medical Weight Loss Specialists, the physicians, employees, and volunteers who work there.

**Privacy Officer Contact**: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Active Medical Director at Address: 3175 Sienna Dr S Fargo, Nd 58104 (701) 205-3088

I, the undersigned, have reviewed the information on this document, and have had an opportunity to ask questions and have them answered to my satisfaction. I understand that payment is due at time of service and may include charges incurred for No Show appointments. Checks will not be held for deposit at a later date. I also understand that if payment is not made, I agree to pay any fees incurred while collecting payment along with a $25 fee for any returned check. Guarantor (myself) understands that I will be responsible for the balance and up to an additional 40% of the balance if the account is placed for collections with a third party agency. I understand that MWLS does not file medical insurance claims and cannot guarantee that insurance will reimburse for services provided. I understand MWLS physicians have additionally opted out of Medicare payment benefits, thus Medicare may not reimburse you for services provided here. You are responsible for notifying us if you receive Medicare for further required information. Please sign here to confirm your responsibility.

_____ _____

Patient Signature Date

Dear Valued Patient,

Please take the time to review our no-show/cancellation policy.

When you schedule an appointment we set aside enough time for the Physician/Nurse Practitioner to provide you with the highest quality care. If you need to cancel or reschedule an appointment please be courteous to our other patients and staff and contact our office right away. Giving us at least 48 hours before your scheduled appointment allows us to schedule other patients who might need to see a provider.

Patients that do not show up for a scheduled appointment, and who have not contacted our office at least 24 hours before the appointment, will be considered a No Show and charged a $25.00 fee.

We do realize circumstances can change at the last minute. If you were unable to make a scheduled appointment due to extenuating circumstances please call the office and ask for our Practice Administrator who may be able to waive the No Show fee.

**Appointment No Show Policy**

Effective January 1st, 2015, patients who fail to present for a scheduled appointment, without contacting the practice at least 24 hours prior to their appointment, will be considered a "no show" and will be charged a fee of $25.00.

Should you need to cancel or reschedule your appointment, this must be done at least 24 hours prior to the appointment. This allows other patients who may be waiting to see the provider, to use the available appointment time.

Patients who wish to request an exception (for extenuating circumstances) will be directed to speak to the practice administrator, who will make the final decision on a waiver of the no show fee. We do realize that on occasion, circumstances change at the last moment and will allow for extenuating circumstances.

Patients who are assessed a no show fee must pay the fee at the time of their next visit. If a no show fee is not paid in a timely manner, the fee will be sent to collections.

Please be courteous to our staff and other patients and give as much notice as possible for appointments that are not able to be kept. Thanks so much for your attention to this matter. Have a great day!

I_____ have reviewed the above new policy.

_____Signature _____Date

_____Witness Name

_____Witness Signature _____Date