CONGRATULATIONS! You have taken the first step in having the healthy body you've always dreamed of. Now that you've taken the first step in scheduling an appointment, below are a few things we'd like you to remember for your first visit.

1. Please arrive at least 30 minutes prior to your appointment time, with your forms completed. This will ensure that you are seen in timely manner.
2. There is a non-refundable $59.00 consultation that applies towards the cost of whichever program you and the doctor feels is best for you.
3. All programs must be paid in advance of receiving treatment.
4. Please do not wear any tight undergarments such as Spanx and other body-slimmers, pantyhose, etc. Your body measurements will be taken, and tight undergarments do not allow for accurate results.
5. Do not exercise 8 hours prior to your consultation.

Again, we congratulate you on taking the first step towards better health! We look forward to being able to serve you.

WeCareMD
Weight Loss Solutions

WEIGHT LOSS SOLUTIONS

NO SHOW POLICY

Patient Name:________________________ **DOB:**___________________

Please note that all cancellations must be made 24 hours in advance of your appointment time. If you fail to cancel without a 24 hour notice, you will be charged a "no show" fee of $50.00. In order to give you the best medical care, your compliance with appointments is necessary.

The weight loss consult fee is $59.00, and must be paid at the time your appointment is made. Consult fees are non-refundable.

***New patients who miss appointments without proper notice cannot be rescheduled.**

_________________________________ _____________________

(Patient signature) **(Today's date)**

_________________________________ _____________________

(Office Signature) **(Today's date)**

WEIGHT LOSS SOLUTIONS

PATIENT INFORMATION

Name____

S.S.# ______________________ Date of Birth:______________________

Sex: M F Marital Status: S M W D

Address:____

____

Phone: (H)________________ (C)________________ (W)______________

Email: ____

Emergency Contact:______________________ Phone:________________

Student Status: _____ Full –Time _____ Part- Time

Employer: ____

Address: ____

____

Referred by: ____

Signature:_________________________ Date: __________________

Weight Loss Solutions
Controlled Medication Policy

In compliance with current standards of care as well as state and federal regulations, WeCareMD, P.C. has a very strict protocol when dispensing controlled medications. We require that patients be seen by the provider **for every refill**. We feel it is a shared responsibility between doctor and patient to use these medications both prudently and wisely, and that this is in the best interest of our patients.

OUR GUIDELINES ARE AS FOLLOWS:

1. Given the nature of your weight loss needs, your provider, will decide if weight loss medications are suitable for you. It is your responsibility to make and keep your appointments. Failure to do so could result in termination of your care.

2. **We will be dispensing all of your medications from our facility**. If, at any time, it is discovered that you are using more than one physician for the same medication, we reserve the right to terminate your care.

3. We ask patients to inform us of their present medications. Please tell us of any new medications that you have received from other physicians, regardless of the type of medication. It is your responsibility to make sure that any new prescriptions that you receive from other physicians are not similar or the same medications. Obtaining medications for weight loss from any other physician may result in a potentially harmful situation.

*****You will be dispensed a 30 day supply of your weight loss medications from our clinic and therefore you must follow the above guidelines in order to be compliant.**

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Patient Name:_______________________ DOB:____________________________

PATIENT'S SIGNATURE:____

DATE:____

We Care M.D.
...we really do care!

Nutritional Evaluation

Patient Name_______________________________ DOB:_______________________________

Present weight __________Height(no shoes):_________ Desired Weight:_______________________

In what time frame would you like to be at your desired weight?_______________________________

Birth Weight:_____Weight at age 20 years of age: _____Weight one year ago _______________________

What is the main reason for your decision to lose weight? _______________________________

When did you begin gaining excess weight? (Give Reasons, if known)_______________________________

What has been your maximum lifetime weight (non-pregnant) and when_______________________________

Previous diets you have followed: _______________________________

Give dates and pounds los: _______________________________

Is your spouse, fiancée or partner overweight? Yes / No

By how much is she or he overweight? _______________________________

How often do you eat out? _______________________________

What restaurants do you eat at? _______________________________

How often do you eat fast foods? _______________________________

Who plans your meals? _______________ Cooks? _______________ Shops? _______________

Do you use a shopping list? Yes / No

Food Allergies: _______________________________

Food Dislikes: _______________________________

Food you crave: _______________________________

Any specific time of the day or month do you crave food? _______________________________

Do you drink coffee or tea? Yes / No How much daily? _______________________________

Do you drink cola drink? Yes / No How much daily? _______________________________

Do you drink alcohol? Yes / No

What? _______________ How Much? _______________ How Often?_______________

Do you use a sugar substitute? _______________Butter? _______________ Margarine? _______________

WELCOME TO WECAREMD

We are committed to giving you the care you need with the attitude you deserve. Please assist us in giving you the best healthcare experience possible. Please note our office polices below, and if you have any questions, please feel free to ask one of our friendly professionals on staff.

FINANCIAL POLICES

We participate in most healthcare plans. It is the patient's responsibility to make sure we have the most recent insurance information on file. **If we are not contracted with your insurance company, we require full payment at the time of service.** Furthermore, if WeCareMD has filed your claim and not received payment from your insurance within 90 days, the remaining balance is the patient's responsibility, and it is up to the patient to obtain reimbursement from their insurance. Due to contractual agreements with managed care plans and in accordance with the Office of Inspector General, **we are legally obligated to collect your co-pay. All co-pays, deductibles, co-insurance and self-pay fees are due at check in**. We accept the following methods of payment:

- Cash
- Credit/Debit cards
- Checks
- *PLEASE NOTE THAT CHECKS ARE NOT ACCEPTED FOR THE WEIGHT LOSS PROGRAM

HEALTHCARE POLICIES

WeCareMD is a full service family practice facility. We treat most minor illnesses and we are happy to manage your overall healthcare, and refer out to other specialists when necessary. **However, we reserve the right to withdraw from treating you if we feel the doctor/patient relationship isn't compatible, or if we feel prescription medications are being abused or for medical or financial non-compliance.**

APPOINTMENT NO-SHOW POLICY

Due to the high volume of calls we receive for appointments, it is our policy that 24 hours notice is required for cancellation. Failure to call 24 hours prior to your appointment to cancel will result in a no-show charge of $50.00 for routine or sick appointments and $75.00 for annual exams or procedures. Two no-shows will result in termination of care at WeCareMD.

PRESCRIPTION POLICIES

Prescription refills can take 24-48 hours to complete. It is necessary for you to call the office well enough in advance so that your prescription can be refilled prior to running out. Some prescriptions require labs prior to each refill, and some require the doctor to assess your condition prior to refilling. Please communicate with our office if you feel your medication will require such services. ****Prescriptions are refilled during regular office hours only and will not be issued on weekends, holidays or after hours.****

AFTER HOURS CARE

Treatment is rendered during regular office hours only. If you are having a medical emergency, please call 911 or report to the nearest emergency room. Please inform the hospital staff if we are your primary care physician and they will be sure to contact us.

Signed____ Date______________________

WeCareMD Weight Loss Solutions
No Refund Policy

I understand that there are no refunds, returns or credit for this program. There is no weight loss guarantee with our program. I understand that results may vary and depend greatly on my compliance with the program guidelines provided to me.

____
Patient Name (Please Print)

______________________________ Signature	______________________________ Date
______________________________ Witness	______________________________ Date

We Care M.D.
...we really do care!

Patient History

Patient Name______________________________ **DOB**____________________

Medication/dosage (include all supplements)	Surgeries/dates	Allergies

Do you have any of the following medical conditions?
☐ Diabetes ☐Arthritis ☐Aids ☐Asthma or lung ☐Heart ☐Stroke ☐Cancer
☐Seizures ☐Reflux ☐High Blood Pressure ☐Mental/Nervous Disorder
List any other____

Do any of the following medical conditions run in your family?
☐ Diabetes ☐Arthritis ☐Aids ☐Asthma or lung ☐Heart ☐Stroke ☐Cancer
☐Seizures ☐Reflux ☐High Blood Pressure ☐Mental/Nervous Disorder
List any other____

Do you currently smoke? ☐Yes ☐No Packs per day___ for ___ years
Are you exposed to second hand smoke? ☐Yes ☐No
Did you ever smoke in the past? ☐Yes ☐No Packs per day___ for ___years
Do you drink alcohol? ☐Yes ☐No Drinks per week___________

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information (please print clearly):

Last Name | First Name | Middle Initial | Date of Birth (Month/Day/Year)

Street Address | Apt. #/P.O. Box# (Please Include Complete Mailing Address) | Medical Record # / Social Security # (Optional)

City | State | Zip Code | Primary Contact Number

If we cannot reach you at the telephone number listed above, WeCareMD may contact you (including leaving messages) regarding appointments or normal lab results at the following number(s):

Home Phone Number | Cell Phone Number | Work Phone Number

I authorize WeCareMD to disclose Protected Health Information to the following persons:

☐ Spouse: Name | Phone Number

☐ Child(ren): Name | Phone Number

Name | Phone Number

☐ Other: Name | Phone Number

Information to be disclosed:

☐ All Medical Information / Lab Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WeCareMD location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WeCareMD cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WeCareMD is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:
(date authorization signed by patient or Legal Guardian/Personal Representative) Month/Day/Year

Print Patient Name or Name of Legal Guardian/Personal Representative | Signature of Patient or Legal Guardian/Personal Representative

Indicate Relationship to Patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WeCareMD Weight Loss Solutions
HCG Diet Informed Consent

HCG is a prescription medication used by WeCareMD Weight Loss Solutions in its weight loss program. The active ingredient in these (HCG) is FDA-approved as an injectible for indications other than weight loss. A number of studies and scientific articles have been published on using this ingredient in weight loss programs over the past 60 years.

Conditions of Participation

- You will have a consultation before starting the HCG in combination with a VLCD (very low calorie diet). A comprehensive metabolic panel to measure kidney function, liver function, hemoglobin, hematocrit, will be drawn.
- You will be weighed; and measured, and your blood pressure and pulse will be recorded.
- You will have a body composition analysis (Q4) to determine your ratios of fat, water and lean muscle
- Any patients who are not compliant with follow up office visits will not be allowed to have refills on their HCG injections.
- If at any time during your office visit, you should have any questions, concerns, or problems, you are encouraged to consult with our staff. If you should experience any problems or concerns after being discharged from our office, please call 770-943-7808 with any questions.

Program Costs

Initial consultation, weight, measurements and Q4 Body Composition Analysis, and labs. Dispensing of HCG injections. Review of diet for the next month. Consultation fee is $79.00 (non refundable) and will be included in the total cost of the program. The total cost of the program is $549.00, which includes all HCG injections, Lipotrophic/B12 injections, labs, six office visits, and two Q4 Body Composition Analyses.

Risks

Our HCG injections are virtually free of negative side effects. However, you must follow a very low calorie, low fat diet. This diet can sometimes trigger a gallbladder attack in individuals who are genetically pre-disposed to gallbladder disease. Taking weight loss supplements can cause low blood sugar as can overeating or under eating on the diet. Not following the diet to the letter or skipping meals/fruit will result in less weight loss and possible side effects. **With any drug there is the possibility of an allergic reaction or unusual reaction that may cause skin rash, difficulty breathing, collapse, or even death.**

I understand that the program and medications may involve risk. I understand that there are no refunds, returns or credit for this program. There is no weight loss guarantee with our program. I have read and understand the information given to me about the medications. I have asked and had answered any questions that I may have after reading this form. I understand the possible side-effects and agree to advise our office should they occur. I understand that I may quit the program at any time. I agree to stop the HCG injections if I become pregnant and agree to advise our office should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact our office. The **WeCareMD Weight Loss Solutions medical providers are** serving as consultants, not your primary care physician, during the course of this program.

My Primary Care Physician is ______________________________. **You will not be allowed to start on this program if you do not have a primary care physician.** If I experience an emergency situation, I understand that I need to go to an emergency facility.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR HEALTH STATUS OR MEDICATIONS PRESCRIBED.
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE DIET NECESSARY TO ACHIEVE SUCCESS ON THIS PROGRAM. I WILL TAKE THE PRESCRIBED POTASSIUM SUPPLEMENT AS DIRECTED. I WILL FOLLOW THE DIET STRICTLY.

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Witness Date