Cape Integrative Care- Medical Weight Loss & Family Practice

New Patient Demographics

Patient Name: _____ Date of Birth: _____

Social Security: _____ Gender: o Male o Female

Address: _____ City: _____ State: _____ Zip:_____

Please check which phone number we can reach you at and leave a message. oHome Phone: _____

oWork Phone: _____ oCell Phone: _____

Email Address: _____

Would you like to participate in our Patient Portal? o Yes o No

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Employer Name: _____ Phone Number: _____

Pharmacy Name: _____ City: _____ State: _____

Mail Order Pharmacy Name: _____ Phone Number: _____

I grant permission to view my prescription history from external sources: o Yes o No

Insurance Information:

oCommercial oMedicare oMedicaid oWorker's Compensation oNone oOther: _____

Primary Insurance: _____Policy # _____ Group # _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

oCommercial oMedicare oMedicaid oWorker's Compensation oNo Fault oOther: _____

Secondary Insurance: _____Policy # _____ Group # _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE I hereby authorize Cape Integrative Care to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Cape Integrative Care-Medical Weight Loss & Family Practice. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either myself or my insurance company at any time in writing. If my insurance company denies payment for services provided by Cape Integrative Care-Medical Weight Loss & Family Practice, I authorize Cape Integrative Care-Medical Weight Loss & Family Practice to initiate an internal appeal, external appeal, and/or arbitration of the denied claim(s) on my behalf. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. Please be advised that you will be responsible for any balance, in which your plan indicates is your responsibility, on their explanation of benefits EOB form, including, but not limited to non covered and not medically necessary services, All patients will be responsible for their copay, co-insurance and deductible. Should you receive payment directly from your insurance carrier, please forward it to our billing department.

Signature: _____ Date: _____

(Revised 12/04/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

New Weight Loss Intake Form

Patient Name: _____ Date: _____

Past Medical History/Review of Systems

Please check the following conditions that apply to you.

Musculoskeletal

__ Headache
__ Joint stiffness/swelling
__ Spasms/cramps
__ Broken/fractured bones
__ Strains/sprains
__ Back, hip pain
__ Shoulder, neck, arm, hand pain
__ Leg, foot pain
__ Chest, ribs, abdominal pain
__ Problems walking
__ Jaw pain, TMJ
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Bone or joint disease
__ Other: _____

Circulatory and Respiratory

__ Dizziness
__ Shortness of breath
__ Fainting
__ Cold feet or hands
__ Swollen ankles
__ Pressure sores
__ Varicose veins
__ Blood clots
__ Stroke
__ Heart condition
__ Allergies
__ Sinus Problems
__ Asthma
__ High blood pressure
__ Low blood pressure
__ Lymphedema
__ Other:_____

Skin

__ Rashes
__ Allergies
__ Athlete's foot
__ Warts
__ Moles
__ Acne
__ Cosmetic surgery
__ Other:_____

Digestive

__ Nervous stomach
__ Indigestion
__ Constipation
__ Intestinal gas/bleeding
__ Diarrhea
__ Diverticulitis
__ Irritable bowel syndrome
__ Crohn's disease
__ Colitis
__ Adaptive Aids
__ Other:_____

Nervous System

__ Numbness/tingling
__ Twitching of face
__ Fatigue
__ Chronic pain
__ Sleep disorders
__ Paralysis
__ Cerebral Palsy
__ Epilepsy
__ Multiple Sclerosis
__ Muscular Dystrophy
__ Parkinson's Disease
__ Spinal cord injury
__ Other:_____

Reproductive System

__ Pregnancy
__current __previous
__ PMS
__ Menopause
__ Pelvic Inflammatory Disease
__ Endometriosis
__ Hysterectomy
__ Fertility issues
__ Prostate problems
__ Other:_____

Other

__ Loss of appetite
__ Forgetfulness
__ Confusion
__ Depression
__ Difficulty concentrating
__ Hearing impaired
__ Visually impaired
__ Eating disorder
__ Diabetes
__ Fibromyalgia
__ Cancer
__ Infectious disease
__ Other congenital or acquired disability
__ Weight gain
__ Other:_____

Surgical History

Date	Procedure	Physician	Hospital	Notes

Current

Physicians

Name	Specialty	Phone number	Last seen

Females only:

What was the date of your last menstrual period? _____

Are you pregnant? _____

Medication

Medication Name	Dose	Last Taken

Family History

Are you adopted?_____ If yes, can you fill out the following concerning your *natural* parents? If not, mark N/A.

Is your father alive?_____ If yes, how old?_____ If not, what was the cause of death?

Is your mother alive?_____ If yes, how old?_____ If not, what was the cause of death?

Is there any disease or illness in your family? (parents, siblings, children, aunts, uncles, grandparents)_____

If yes, list what they are and who suffered from them._____

In particular, does anyone have: (If yes, write "F" for father, "M" for mother, "S" for sister, "B" for brother)

__ Heart disease __ Lung disease __ Liver disease __ Kidney disease

__ Cancer __ Stroke __ Diabetes __ Asthma

__ Tuberculosis __ Arthritis __ Chronic pain __ Headaches

__ Scoliosis __ Trouble sleeping __ Mental Illness __ Other:_____

Social History

Do you drink alcohol?___ If yes, what type and amount per week?

Do you use tobacco or smoke?___ If yes, what type and amount per day?

Did you ever use tobacco or smoke?___ If yes, for how long and when did you quit?

Do you use recreational drugs?___ If yes, what type and how often?

Do you consume caffeine?___ If yes, what type and amount per day?

Do you exercise?____ Describe:_____

What are your top 5 favorite foods?_____

What do you typically drink for beverages throughout the day?_____

What time do you go to bed?_____ How much do you sleep per night?_____ What position do you sleep in?_____

What are your hobbies?_____

How many hours per day do you perform the following? Lifting____ Sitting____ Bending____ Computer use____

Do you experience an abnormally high amount of stress? If yes, from what?_____

Cape Integrative Care- Medical Weight Loss & Family Practice

Patient Informed Consent for Appetite Suppressants

I,_____ (patient or patient's guardian) authorize Dr. R. Daniel Bieser, to assist me in my weight reduction efforts. I understand 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 treatments may include a very low calorie diet, or a protein supplement 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 safely and successfully in private medical practices, as well as in academic centers for periods exceeding those recommended in the product literature.

I have read and understand my Doctor's statements that follow:

> "Medications, including the appetite suppressants have labeling worked out between the makers of the medication and the Food and Drug Administration. The labeling contains, among other things, suggestions for using the medication. "
>
> "As a physician, I have found the appetite suppressant helpful in periods far in excess of 12 weeks, and at times, in larger doses than those suggested in the labeling. As a physician, 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, recent longer term studies and recommendations of the university based investigators. Based on these, I have chosen, then indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."
>
> "Such usage has not been 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)."
>
> "As a physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressants 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 side effects, even if they might be serious, for the possible help the appetite suppressants used in this manner may give."

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

I understand there are other ways and programs that can assist me in my desire to decrease body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will depend on my progress in weight reduction and weight maintenance. Further, a balanced calorie counting program or an 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 suppressant.

Risk of Proposed Treatment

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

Cape Integrative Care- Medical Weight Loss & Family Practice

Lipo-B/B12 Injection Consent

Patient Name_____ Date of Birth_____

Screening Questionnaire

1. I am allergic to Sulfa.	Yes___	No___
2. I am allergic to Lidocaine.	Yes___	No___
3. I am allergic to anything in the "caine" family.	Yes___	No___

Home Administration

There is a slight possibility of an allergic reaction to the Lipo-B/B12 injections and clients who have never had a reaction could possibly have one even though they have never had one before. In our office, we are prepared to handle such a reaction and must ensure that the conditions set forth below will be met by clients taking them home to be administered off-site.

1. The person taking the Lipo-B/B12 injections will have a licensed EMT, MA, LPN, RN, FNP, Pharmacist, or Doctor administer the injection.

2. The person taking the Lipo-B/B12 injections will make sure that the person administering the injection has Epinephrine and Benadryl on hand to counteract any allergic reactions which may occur from receiving the injections.

3. The person taking the Lipo-B/B12 injections will keep them refrigerated until use, take care not to push down the plunger during transportation, and have them administered in a safe and sterile environment.

4. The person taking the Lipo-B/B12 injections outside of this office, will hold harmless Cape Integrative Care- Medical Weight Loss & Family Practice, it's staff and owners, from any and all liability associated with injections when not administered in our office should an allergic reaction or other problem occurs.

5. The person signing this consent understands that these precautions must be taken in order to have the convenience of offsite injections readily available to them.

I accept and understand the terms and conditions and consent to receive Lipo-B/B12 injections.

Signature_____ Date_____

(Revised 12/4/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

Authorization to Release Medical Records

_____ _____ _____ _____

Printed Name | Patient's Social Security Number | Date of Birth | Today's Date

Address_____

Street Address | City | State | Zip Code | Phone

_____ _____

Signature of Patient or Patient's Representative | Relationship of Representative to Patient

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: _____

_____

_____

To: Cape Integrative Care- Medical Weight Loss & Family Practice

2441 Myra Drive Cape Girardeau, MO 63703

Phone: 573-803-0919 Fax: 573-818-2508

The information to be released includes:

Entire Medical Record_____ Other_____

The Medical Record Information will be used and/or disclosed for the following purposes:

At the request of the individual_____ Changing Primary Care Physician_____ Changing/seeing Specialist _____

Other (write purpose here)_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please **exclude** the following information, if it is part of my Medical Record information *(Check any or all you want excluded from this authorization for use or disclosure):*

__ Chemical Dependency/Substance Abuse __ Psychiatric/psychological conditions __Sexually Transmitted Diseases

__Alcohol __ Drugs __ N/A

I understand that this Authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this Authorization at any time by notifying Cape Integrative Care- Medical Weight Loss & Family Practice in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cape Integrative Care-Medical Weight Loss & Family Practice before receiving my revocation. I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

Cape Integrative Care- Medical Weight Loss & Family Practice

Financial Policy

Thank you for choosing Cape Integrative Care as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. **Patients are responsible for understanding their health insurance coverage(s) and benefits**. There may be limitations and exclusions to coverage. **You are responsible for any charges not covered by your plan.**

Insurance Accounts: We ask that you present your insurance card at **every visit**. If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date** of service a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. ***Self-pay patients are responsible for paying 100% of charges at the time services are rendered.***

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third party liability information **within 30 days of the date of service** may result in any unpaid balances transferring to patient responsibility. ***Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.***

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Financial Policy

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash or money orders are also acceptable methods of payment.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. Your failure to appear for a scheduled appointment or to cancel an appointment **at least 24 hours prior to the visit** may result in a missed appointment fee. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date

(Revised 12/04/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

HIPPA Notice of Privacy Practice

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPPA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience. The full Practice Privacy Policy and Assignment of Benefits Agreement is available here for you to read or you can ask for your own copy.

This Notice of Privacy Practice describes the ways we are allowed by law to use your protected information (medical records) or PHI to carry out treatment, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your provider will use your PHI as he/she has always done for treatment, payment, or other health care operations. In addition we may also disclose you PHI from time to time to other providers or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. Front desk sign in sheets will be used where you will be asked to sign your name and we will call you by name in the waiting room when your provider is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us, including billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your provider will try to obtain your consent as soon as possible. Your PHI may be disclosed to a public health agency or law enforcement as needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI for purposes of treatment, payment or health care operations, also that it not be disclosed to family members. This must be specific and in writing. However, you provider is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know whom we have revealed your information if it is other than for treatment, payment, or healthcare operations.

You have the right to a paper copy of this notice upon request. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing such a complaint.

By signing this form, you authorize all medical service sources and healthcare providers to use and/or disclose the PHI for treatment and care. In addition, you authorize the disclose of information regarding billing, condition, treatment, and prognosis to the following individuals, all of whom collaborate under Cape Integrative Care- Medical Weight Loss & Family Practice: Ashley Uchtman, Holistic Provider; Kendrick Morris, Healthcare Provider; Debbie Evans, Healthcare Provider; Laura Murphy, Healthcare Provider; Karen Graham, Healthcare Provider, Robert Bieser, Healthcare Provider; Susan Anglin, Facial Specialist

Individual(s) listed below are authorized to receive medical information:

_____

_____

_____

Signature_____ Date_____

(Revised 12/04/18)