WEIGHT LOSS AND WELLNESS CENTER
Metabolic and Diabetes Surgery

Saniea F. Majid, MD., FACS, FASMBS
Phone :(973)795-7955
Fax: (973)795-7909
www.weightlossandwellnesscenter.com

WELCOME TO WEIGHTLOSS AND WELLNESS CENTER

PATIENT INFORMATION

Last Name	First	M.I.	Birthdate:
Street Address		Apartment/Unit #	
City	State	ZIP	
Home Phone	Cell Phone		
Social Security No	Sex Male ☐ Female ☐	Marital Status M ☐ S ☐ D ☐ W ☐	
Email Address:			
How did you hear about us? Physician ☐ Internet ☐ Flyer ☐ Previous Patient/Friend ☐			

Emergency Contact:	Telephone:
Primary Doctor:	Telephone:
Pharmacy:	Telephone:

PATIENT INSURANCE INFORMATION

****PLEASE PROVIDE INSURANCE CARD AND PHOTO ID TO RECEPTIONIST****

Primary Ins:	ID Number
Policyholder:	Group Number
Secondary Ins:	ID Number
Policyholder:	Group Number

Ethnicity: (optional)	☐ African American ☐ American Indian/ Alaska Native ☐ European American ☐ Hispanic/ Latino ☐ Middle Eastern	Race: (optional)	☐ Black/ African American ☐ American Indian/ Alaska Native ☐ Caucasian ☐ Middle Eastern ☐ Asian/ Pacific Islander

BENEFITCIARY STATEMENT AND SIGNATURE

I request and give consent to receive healthcare services from Weight loss and Wellness Center as provided by the medical staff. I authorize and request that Weight loss and Wellness Center performs assessments, administer treatments and medications, and obtain laboratory tests as they believe may be considered advisable in the diagnosis and treatment of my condition. I realize that no particular outcome/result can be guaranteed as a result of my consent to treatments at the Weight loss and Wellness Center and that there are possible complications that may result from the course of treatment, I choose which was explained to me, and I understand the risks versus benefit assessment. I hereby release Weight loss and Wellness Center from responsibility from any injury or other adverse outcome that results from my leaving Weight loss and Wellness Center services against clinical and medical advice. I acknowledge and understand that I have read this consent or have had it read to me in my preferred language and agree that the information referred to in it has been discussed with me. I have been given an opportunity to ask further questions about any areas which were not clear to me and I am satisfied with the explanation and all of my questions have been answered.

Signature: Date

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General Consent and Acknowledgement

Patient Name: _____ **Date of Birth:** _____

General Acknowledgements:

☐ Weight loss and Wellness Center may leave a message on my/my family's voicemail confirming appointments and/or information requested by me regarding treatments and/or medications.

☐ Weight loss and Wellness Center may not leave a message on my/my family's voicemail.

Consent to Treat:

I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed be performed by employees, including but not limited to physicians, mid-level provider (Physician Assistant or Nurse Practitioner), certified medical assistants, and radiology technician of Weight loss and Wellness Center.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I understand that my protected health information will be used by Weight loss and Wellness Center, as necessary, for my treatment, to obtain payment for treatment, and for the healthcare care operations Weight loss and Wellness Center. I also understand that my protected health information will be disclosed to other Weight loss and Wellness Center affiliated if needed for the purpose of furthering my treatment, to obtain payment for treatment and for the healthcare operations for Weight loss and Wellness Center.

I understand that Weight loss and Wellness Center will warn the appropriate authorities and/or other individuals if my Weight loss and Wellness Center medical provider determines that I am a harm to myself or others.

Patient Signature (if 18 years old) or Legal Guardian if a minor **Date**

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IMPORTANT OFFICE POLICIES

SCHEDULING APPOINTMENT-EMERGENCY CASES

Weight Loss and Wellness Center understand that you need to see your physician that is why we ask that you schedule appointments ahead of time. That way you can receive the necessary care from our physicians. We understand that there are emergency cases/sick visits in which you would like to see your physician. If a physicians' schedule is full our staff will do what we can to accommodate you and provide you with other physicians/providers in our practice to take care of you.

REFERRAL/PRIOR AUTHORIZATION POLICY

I understand that it is my responsibility to obtain a referral/authorization through my primary care physician's office if required by any consulting physicians and/or diagnostic centers. We ask that you obtain all necessary referrals from your primary and provide to us at the time of your visit.

MEDICAL CLEARANCE POLICY

For all surgical procedures you will be required to have a medical clearance performed by your primary care physician and a cardiologist (if applicable).

PRESCRIPTION/REFILLS OF MEDICATIONS

Regarding prescription refills, please note the following:

- Prescription requests submitted after 5:00 pm will not be called in until the next day.
- When leaving a message with our staff regarding prescription refills please include as much information as possible, including the following:
    - Complete name with spelling of last name and date of birth.
    - Name of the pharmacy and phone number
    - Name of the drug and prescription number if available
    - Any allergies or allergic reaction to any mediation.
- The law prevents us from phoning in **ANY** prescriptions for narcotics to your pharmacy. If a refill is appropriate, your doctor will write a prescription that can be picked up during business hours. Please allow ample time for this process.
- We do not refill prescriptions over the weekend. Be sure to submit you request before 3:00 pm on Friday if you need your prescription filled before Monday.

NARCOTICS/CONTROLLED SUBSTANCES POLICY

The physicians of Weight Loss and Wellness do not routinely prescribe narcotics on a long-term basis, nor do we administer narcotics by injection in the clinic. No narcotic medications are kept on site. Individuals who are seeking "pain killer" for chronic use are hereby advised to seek treatment with the appropriate pain management clinic, or if the pain is severe, with the local hospital emergency department. When indicated, long-acting opiates are prescribed in extremely limited quantities without automatic refills. **Narcotic prescriptions will not be refilled after office hours or on weekends.**

It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore, patients who do seek narcotic prescriptions through this office agree that, unless otherwise indicated by Weight Loss and Wellness we are to be the sole prescribing physicians for the patient. Furthermore, patients desiring prescriptions for controlled substances from our office agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine multiple physicians are ordering prescriptions for pain medications we will immediately cease all orders for such treatment from our office.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

_____ _____

Signature of Responsible Party **Date**

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Patient Information and Photo/Video/Social Media Release Form

Your health is a personal matter. As your health care provider, Weight Loss and Wellness Center ("WLWC") recognizes and works hard to assure your privacy. We strive to comply with all state and federal patient privacy requirements, such as the national Health Insurance Portability and Accountability Act, known as HIPAA. Under these regulations, we request that you authorize use of your health information for purposes other than treatment, payment, and health care operations

I authorize the use/disclosure of my photo/voice /health information as described below:

1. WLWC Marketing & Communications Department
   - ☐ For use in marketing/promotional purposes
   - ☐ For use in printed advertisement or brochure
   - ☐ For use on social media
   - ☐ For use on our website
   - ☐ All the above

2. Information/images that may be used/disclosed:
   - ☐ All information/images
   - ☐ Full Name
   - ☐ First Name only
   - ☐ Gender
   - ☐ Age
   - ☐ Your comments regarding your medical condition, treatment and/or experience
   - ☐ Your comments made during an interview
   - ☐ Photographs, recordings, videos or other creative images

3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

4. I waive my right to royalties.

5. I waive my right to inspect or approve finished product, wherein my likeness appears.

6. I understand that I may revoke this authorization in writing at any time. However, this will not affect any uses or disclosures of information that were made based on my prior authorization.

_____ _____

Patient Signature **Date**

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Patient Medical Information

SOCIAL HISTORY

		Amount	Frequency
Alcohol	Yes ☐ No ☐		
Smoking	Yes ☐ No ☐		
Recreational Drugs	Yes ☐ No ☐		

MEDICAL HISTORY: (Check all that apply)

Cardiovascular Disease

- ☐ Angina Assessment
- ☐ Congestive Heart Failure
- ☐ DVT/PE
- ☐ Hypertension
- ☐ Ischemic Heart Disease
- ☐ Lower Extremity Edema
- ☐ Peripheral Vascular Disease

Gastrointestinal

- ☐ Cholelithiasis
- ☐ GERD
- ☐ Liver Disease

General

- ☐ Abdominal Hernia
- ☐ Abdominal Skin/Pannus
- ☐ Functional Status
- ☐ Pseudotumor
- ☐ Stress Urinary Incontinence

Metabolic

- ☐ Diabetes
- ☐ GOUT/Hyperuricemia
- ☐ Lipids (Dyslipidemia or Hyperlipidemia)

Musculoskeletal

- ☐ Back pain
- ☐ Fibromyalgia
- ☐ Musculoskeletal Disease

Psychosocial

- ☐ Alcohol Use
- ☐ Confirmed Mental Health Diagnosis
- ☐ Depression
- ☐ Psychosocial impairment
- ☐ Substance Abuse (prescription or illegal drugs)
- ☐ Tobacco use

Pulmonary

- ☐ Asthma
- ☐ COPD
- ☐ Obesity Hypoventilation Syndrome
- ☐ Obstructive Sleep Apnea Syndrome
- ☐ Pulmonary Hypertension

Reproductive

- ☐ Menstrual Irregularities (not PCOS)
- ☐ Polycystic Ovarian Syndrome

CONDITIONS

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ HBP
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Parkinsons
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEN ONLY	**WOMEN ONLY**	
☐ Breast Lump ☐ Erection difficulties ☐ Lump in Testicles ☐ Penis Discharge ☐ Sore on Penis ☐ Other_____	☐ Abnormal Pap ☐ Bleeding Between Period ☐ Breast Lump ☐ Extreme Menstrual Pain ☐ Hot Flashes ☐ Nipple Discharge ☐ Painful intercourse ☐ Vaginal Discharge	Other:_____ Date of last Menstrual Period: _____ Date of last Pap smear: _____

MEDICATION	**DOSAGE**	**DIRECTIONS**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SURGICAL HISTORY & PROCEDURES: NON BARIATRIC (not weight loss)	Year	Bariatric (weight loss) Surgery	Year
Appendectomy: Open☐ Laparoscopic☐ **Complications**: Yes ☐ No☐		**RYGB (Gastric Bypass)** Open ☐ Laparoscopic ☐ Robotic ☐	
Hysterectomy: Open ☐ Laparoscopic ☐ **Complications:** Yes ☐ No☐		**Sleeve Gastrostomy (Gastric Sleeve)**: Open ☐ Laparoscopic ☐ Robotic☐	
Gall Bladder Removal: Open☐Laparoscopic☐ **Complications:** Yes ☐ No ☐		**BPDS (Duodenal Switch):** Open ☐ Laparoscopic ☐ Robotic☐	
Hernia Repair: Open ☐ Laparoscopic☐ **Complications**: Yes ☐ No☐		**Gastric Band Removal:** Open ☐ Laparoscopic ☐ Robotic ☐	
Abdominoplasty (tummy tuck) Open ☐ Laparoscopic ☐ **Complications**: Yes ☐ No☐		**Revisional Procedures**	
		Endoscopic Balloons (Orbera☐ Reshape☐ Obalon☐ other ☐	
Other:		**Other:**	

HOSPITALIZATIONS		
Year	Hospital	Reason for hospitalization and Outcome

FAMILY HISTORY

	Alive or Deceased	Age	Medical History
Mother			
Father			
Sibling(s)			
Biological Children(s)			

SPECIALISTS

Provider	Reason for Going	Findings	Treatment

ALLERGIES:	**REACTION:**

If you are here for a weight loss consultation, then please complete the following:

Height _____ Current Weight: _____ Usual Weight: _____
Has your weight changed in the past year ? Yes/ No ☐ ☐ If yes, please list _____ pounds☐ Lost ☐ Gained Was it intentiional ? Yes/ No ☐ ☐

Do you exercise? Yes/ No ☐ ☐ If yes, what type and how often? _____
Any medical reason you cannot or should not execerise ? Yes/ No ☐ ☐ If yes, please list : _____

Please rate your current stress level ☐High ☐Moderate ☐Low ☐None
What asss most to your stress ?☐Family ☐ Money ☐Health ☐Work ☐Other: _____

NURTIONAL INFORMATION

Have you met with a Registered dietician in the past? ☐ Yes ☐ No
If yes, when & where ? _____

Do you follow a special diet or eating style?
If yes, when & where ? _____

Please list any strong overall food preferencs:

Who does your grocery shopping ? Myself ☐ Other ☐

Who prepares your meals ? Myself ☐ Other ☐

Do you ever skip meals ? Yes ☐ No ☐ Sometimes ☐

How many meals do you typically eat each day ? _____

Do you any religious practice or food philosphies affect your diet?(i.e. Kosher, Vegetarian?)

What foods do you dislike ?

What foods do you crave?

How often do you eat in front of the TV or Computer ? _____

Do you eat more rapidly than others?
Yes ☐ No ☐ Sometimes ☐

Do you eat until you are feeling uncomfortably full?
Yes ☐ No ☐ Sometimes ☐

Do you have a history of the following? (please check)
Compulsive overeating ☐ binge eating disorder ☐ anorexia ☐ bulmia ☐
Other : _____

What was your lowest body weight as an adult ? _____

What diets have you tried to lose weight ?

How Often do you eat the Following:	**Never**	**2-3 times/mon**	**1 Time/week**	**2-3 Times/week**	**1 times/ day**	**2-3 times / day**
Fast Food						
Resturant Food						
Vending machine Food						
Cafeteria or Buffet Food						
Frozen Meals						
Home-Cooked Meals						
Leftovers						
Beef (hamburgers, steak, etc)						
Pork (chop, loin, ham, bacon, etc)						
Liver						
Lamb						
Poultry (chicken, turkey, etc)						
Deli Meats						
Fish (Type)						
How Often do you eat the Following:	**Never**	**2-3 times/mon**	**1 Time/week**	**2-3 Times/week**	**1 times/ day**	**2-3 times / day**

Soyfoods, (Type)						
Beans (Type)						
Crackers (Type)						
Cookies/ Cakes/ Muffins						
Whole grains, (Type)						
Fresh/ raw vegetables						
Cooked Vegetables						
Fruits : frozen or fresh						
Canned veggies or fruits						
Margarine						
Dairy (milk, yogurt, cheese, butter)						
French fries						
Fried Foods/Meats (chicken, fis, etc)						
Foods with added sweeterners. Sugar						
Artifical sweeteners: (Type)						
Meal Replacements: (Type)						

BEVERAGE TYPE	**Daily amount Ounces/cups and size**	**Weekly amount**	**Monthly amount**
Water : tap☐ filtered☐ Bottled ☐			
Coffee: Regular ☐ Decaf ☐ Latte☐			
Tea: what type _____			
Juice: Natural ☐ Fruit Drinks ☐			
Soda: Regular ☐ Diet ☐			
Millk Alternative type : _____ **Milk Whole 2%☐ 1%☐ skim☐**			
Alcohol : **Wine☐ Beer☐ Liquor ☐**			
Others : _____			

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PATIENT AUTHORIZATION FOR MEDICAL INFORMATION RELEASE

Date: _____

I, _____ hereby authorize,

(Facility/Doctor)_____

(Address)_____

_____

To release information from the records of:

Patient's Name: _____

Patient's Signature: _____

Address: _____

Date of Birth: _____

Tel #: _____

To:

Saniea F. Majid, MD., FACS, FASMBS
Phone: (973) 795-7955
Fax: (973)795-7909
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Method of releasing information: By letter ☐ Fax ☐ Phone ☐

Confidentiality Statement

This information has been disclosed to you from records protected by Federal and State confidentiality rules. The Federal rules prohibit you from making any disclosure of this information unless further disclosure is expressively permitted by the written consent of the person to whom it pertains or as otherwise permitted. Any disclosure, copying, distribution, or taking of any action in alliance on the contents of this information is prohibited.

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HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Complaints
You may complain to our Practice administrator or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

_____
Print Name

_____
Signature

_____
Date

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FINANCIAL RESPONSIBILITY FOR PATIENTS WITHOUT CONTRACTED INSURANCE CARRIERS (OUT OF NETWORK PROVIDERS)

Saniea Majid, M.D. does not have a contract with the Insurance Carrier that provides your medical insurance coverage. Our office has the following policies for Out of Network patients. Please read the following policies carefully, as you will need to accept and agree to abide by these policies.

- All office charges must be paid at the time of service. We accept cash, checks, VISA and MasterCard. As a courtesy to you, we will submit your claim to your insurance company.
- If surgery is recommended and scheduled, you will be required to make a pre-payment prior to the surgery. The amount will be determined after our office contacts your insurance company to obtain an estimated payment amount.
- Many Out of Network Medical Health Insurance Carriers mail their reimbursement payments directly to the patient. If that is anticipated with your plan, I agree to endorse and mail the insurance check to Dr. Saniea Majid, M.D. (along with any documentation that accompanies the check) within seven days of its receipt. Any unreimbursed balance must be paid within 60 days from the date of surgery.
- I agree that if I refuse or fail to fulfill these above-stated agreements, I agree to pay any and all collections costs incurred by the office of Dr. Saniea Majid during the process of collecting full payment for the services provided to me.

<u>Please note that by choosing an Out of Network provider, you accept the fact that you may have a significantly larger out of pocket financial responsibility.</u>

I agree to the above conditions and fully understand my financial responsibility for medical services that I receive from Dr. Saniea Majid is as an out of network medical provider with my Medical Health Insurance Carrier.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____

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ASSIGNMENT OF BENEFITS/ ACKNOWLEDGEMENT OF CO-PAYS AND ADDITIONAL FEES

I, the undersigned, do hereby authorize and demand the assignment of all medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, Workers Compensation insurance, and any liability settlement payments to Weight Loss and Wellness Center.

_____ Initial — I, the undersigned, do acknowledge that I have been informed by Weight Loss and Wellness Center that there will be an insurance determined co-payment due for **each visit**. I agree to pay the required co-payment at the time of each visit and that a $10 service charge may be added to any bill sent to collect a co-pay.

_____ Initial — I hereby authorize Weight Loss and Wellness Center to release all information necessary to secure the payment of said benefits. I understand that the benefits represented to me today are not a guarantee of payment by my insurance company. I acknowledge and understand that my insurance may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due.

_____ Initial — If you are a Medicare patient, we will file claims for your services directly with Medicare and any supplemental insurance that you may have. If you do not have supplemental insurance you will be responsible for paying any unmet deductible and the 20% co-insurance.

_____ Initial — I hereby authorize Weight Loss and Wellness Center to release information from my medical records related to treatment rendered to me during this episode of care. The purpose for releasing said information is to keep the physician, attorney, or insurance company aware of the progress being made.

_____ Initial — I understand that it is my responsibility to provide Weight Loss and Wellness Center with appropriate current insurance information and to notify Weight Loss and Wellness Center. Immediately upon any changes in my insurance coverage to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services rendered to me, and I understand that I may be fully responsible for my entire account balance.

_____ Initial — Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment at Weight Loss and Wellness Center. If my insurance company requires a referral and I do not have one then I understand that I will be responsible for the entire bill for rendered services.

WAIVER OF LIABILITY

_____ Initial — I have been informed by the office staff and fully understand that the services performed, or the supplies by my insurance carrier received, may not be covered or the secondary insurance carrier, regardless of whom files for payment. I realize that anything not covered by my insurance company will be my full responsibility.

THE FOLLOWING APPLIES TO ALL PATIENTS, REGARDLESS OF INSURANCE TYPE

PATIENT DISCHARGE/COLLECTION FEES

_____ Initial

In the event of failure to pay for medical services rendered, I understand that I may be discharged from the services of Weight Loss and Wellness Center until such time as my account is paid. Additionally, I understand that I may be referred to a collection agency for non-payment of fees due for services rendered by Weight Loss and Wellness Center. I understand that I will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process, and that these fees and costs will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance **in addition to** the collection agency fee. Further, I understand that my PHI will necessarily be revealed in these efforts to collect payment for monies owed.

RETURNED CHECK FEE

_____ Initial

I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or a certified check for the full amount of the payment owed, in addition to a $50.00 returned check charge.

MISSED APPOINTMENT FEE

_____ Initial

I understand that I will be charged a $100.00 fee if I miss an office visit without having provided a 24- hour advance notice of cancellation.

CANCELLED PROCEDURE FEE

_____ Initial

I understand that I will be charged a $150.00 fee for cancelling or not showing up to an EGD without having provided a 5-business day advance notice of cancellation.

CANCELLED SURGERY FEE

_____ Initial

I understand that I will be charged a $250.00 fee for cancelling or not showing up to surgery without having provided a 7-business day advance notice of cancellation.

TRANSFER OF RECORDS

_____ Initial

I understand that I will be charged a fee to transfer my records to another physician: $10.00 flat administrative fee, plus $1.00 per page for copying of charts. This payment is due in full prior to the copying and forwarding or records.

I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS ASSIGNEMENT OF BENEFITS AND ACKNOWLEDGEMENT OF COPAYS AND ADDITONAL FEES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORAMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS, OR OTHERWISE OBTAIN PAYMENT, AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE(S) NOT COVERED BY INSURANCE.

_____ _____

Signature Date

Patient/Parent or Legal Guardian

_____

Patient's Name (Print)

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CONSENT TO ENGAGE IN TELEHEALTH AND TELEMEDICINE

- I, _____, consent to engage in telehealth and telemedicine with Weight Loss and Wellness Center. At the time of the telehealth and telemedicine appointment (the "appointment"), I will be located in _____ (identify state of location).

- Weight Loss and Wellness Center has explained to me how the technology used during the appointment works and will be used.

- During the telehealth and telemedicine appointment:

    - Details of your medical history, medical records, examinations, x-rays, and tests will be discussed through the use of interactive video, audio, and/or telecommunication technology
    - A physical examination of you may take place although limited to what can be seen through video
    - Other licensed medical professionals may be present during the appointment
    - Other non-medical staff may be present during the appointment to assist with the technology, but you may request for that non-medical staff to leave the room before continuing the appointment
    - Video and audio recordings, and or photographs, may be taken of you during the appointment

- I acknowledge that I have provided Weight Loss and Wellness Center with a complete medical history and complete medical records before my scheduled telehealth and telemedicine appointment with Weight Loss and Wellness Center, and I provided that history and medical records through Weight Loss and Wellness Center portal Exemplo.

- I understand that there are certain risks in using telehealth and telemedicine including, but not limited to, the following:

    - Information transmitted may not be sufficient due to poor or inadequate quality to allow for appropriate medical decision thus necessitating a face-to-face visit or at least a rescheduled video consult
    - Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
    - Even with the use of [Entity/Provider's] portal [name of HIPAA compliant program], security protocols could fail, causing a breach of your privacy of personal medical information and disclosure to third parties

- I understand that no results have been or can be guaranteed.

- If I have an adverse reaction to the treatment provided to me via telehealth and telemedicine, I will immediately contact your office, unless it is an emergency. If it is an emergency, I will contact 9-1-1 and immediately seek in-person medical assistance.

- If there is a technological or equipment failure, I will contact the [Entity/Provider] by phone using the contact information below. If I have an emergency, I will contact 9-1-1 and immediately seek in-person medical assistance.

- I understand that telehealth and telemedicine should not be used for emergency purposes, and that if an emergency exists, I should contact 9-1-1 and immediately seek in-person medical assistance.

- I have a right to withdraw this consent to the use of telehealth and telemedicine at any time during the appointment.

• I acknowledge that Weight Loss and Wellness Center has provided the identity, professional credentials (license number, title, specialty and board certifications), and the contact information of the health care provider who shall provide the telehealth and telemedicine services to me on behalf of Weight Loss and Wellness Center. I shall use the below information to contact Weight Loss and Wellness Center so I may reach that health care provider or a substitute health care provider authorized to act on behalf of Weight Loss and Wellness Center:

Weight Loss and Wellness Center
65 E. Northfield Rd – Unit K, Livingston, NJ 07039
P: 973-795-7955 | F: 973-795-7909
contact@weightlossandwellnesscenter.com

• I acknowledge that this consent form is for purposes of obtaining the above consent regarding telehealth and telemedicine. I understand that if additional testing or invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above consent regarding telehealth and telemedicine, and all of my questions have been answered to my satisfaction. The risks, benefits and any practical alternatives to using telehealth and telemedicine have been discussed with me in a language in which I understand. I have read and fully understand this form, and I represent that I am signing this consent voluntarily and intend to be legally bound by it.

PATIENT _____ DATE _____

PARENT OR LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____