Doctor's WEIGHT LOSS CENTERS & HERON SMART-LIPO CENTER

321 S Patrick St.
Alexandria, VA 22314
703.549.2626
F: 703.299.5080

Heron Med Spa

Please Fill Out Completely
****

Patient's Name: _____
Last First Initial

Home Ph#:_____ Business Ph#:_____

Cell Ph #: _____ Date of Birth _____
(Required for medical screening)

Home Address: _____
Street

_____
City State Zip

E-mail Address: _____

Nearest Relative Name: _____

Complete Address: _____

Ph #: _____

How did you hear about us?

_____ Drive-by _____ Office Sign _____ Email
_____ Website _____ Friend of DWLC _____ Physician
_____ Social Media (FB,IG) Name_____
Other _____

Have you used a professional weight loss/management program in the past? If yes, which one(s)? _____

Comments: (Did you lose weight? Did you receive counseling? Were you on prescription medication? If so, provide the name of the prescription medication.
_____

_____

Medical & Family History (Please check the ones that apply

Health Care Problem	**Self**	**Father**	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Cancer (type or location							
Heart Disease							
High Blood Pressure							
Stroke							
Lung Disease							
Tuberculosis							
***Diabetes (See page 4)**							
Kidney Disease							
Liver Disease							
Thyroid Disease							
Bleeding Disorder							
Epilepsy/Convulsions							
Osteoporosis							
Mental Illness							

*Diabetics must comply with monitoring. See page 4 for details.

Current Medical History — Please print // list your current medication(s) and reason(s):

_____
_____
_____
_____(Required for medical and prescription medication screening)

Are you allergic to any medications? _____ Yes ___ No

Please List:

_____
_____

Hospitalization or Surgery –Write in the reason and the date

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY – Check all that apply (For immunizations, place a √ and dates (year))		
□ Diphtheria	□ Depression	□ Gall Bladder Disease
□ Hepatitis	□ Nervousness	□ Bowel Irregularity
□ Measles	□ Dizziness/fainting	□ Incontinence
□ Mumps	□ Heart Palpitations	□ Prostate Disease
□ Pneumonia	□ Heart Murmur	□ Sexual/Menstrual Dysfunction
□ Polio	□ Shortness of Breath	□ Breast Disease
□ Rheumatic Fever	□ Chest Pain	□ Venereal Disease
□ Rubella	□ Peripheral Vascular Disease	□ Arthritis
□ Tetanus	□ Allergies/Hay Fever	□ Gout
□ Other Immunizations	□ Asthma	□ Abnormal PAP/Mammogram
□ Scarlet Fever	□ Bronchitis	□ Pregnancies (Number)
□ Chronic Rashes	□ Tuberculosis (TB)	□ Live Births (Number)
□ Mononucleosis	□ Abnormal TB skin test	□
□ Anemia	□ Stomach Ulcer	□
□ Frequent Infections	□ GI Disorder	□
□ Headache	□ Lactose Intolerance	□

Do you want your primary physician to be informed of your progress during the course of this program? ___ Yes ___ No

Name_____ Ph#: _____

Lifestyle

Do you smoke or use tobacco products? ___ Yes ___ No
How much do you use on a daily basis?
Number of cigarettes____ Number of Cigars ____ Amount of chewing tobacco___

Do you drink alcohol? ___ Yes ___ No
How many glasses do you consume on a weekly basis? _____

Do you currently exercise? ___ Yes ___ No
If so, what kind of exercise and how often?_____

Patient Weight Goals

How much total weight do you want to lose? _____lbs Present weight _____ lbs

What is your height? _____

How fast? (Check one)

_____ 5 to 8 pounds per month _____ 10 to 12 pounds per month
_____ 15 to 20 pounds per month

What is your present dress/pant/suit size? _____ What size would you like to wear? _____

Financial/Refund Policies and Patient Responsibility:

- There are **no refunds** for services rendered for our weight management fees. All applicable payments must be made in advance of service. We offer no payment plans.
- **Health Insurance is not** accepted by Doctor's Weight Loss Centers, Inc.
- Individuals with flexible spending accounts will receive appropriate documentation to receive reimbursement from their employer. Allow 5-7 working days for preparation.
- Patient will pay for follow-up lab work at their own expense every 4 months to remain on prescription medication and provide current EKG and physical upon request.

I attest that all the above information is true. I have also read and understand the refund / financial policies and patient responsibility mandated by Dr. Heron and the Doctor's Weight Loss Center's staff.

Patient Signature:_____ Date:_____

FOR PATIENT'S **WITH DIABETES**:

If you ARE a *diabetic and take prescription medication for your diabetes, you MUST visit with your primary care physician for close monitoring of your medication and sugar levels while on our weight loss program. **A signed agreement from your physician** must be provided for your file **BEFORE** you are accepted on our weight loss program. Failure to do so will expel you from our program.

Patient Signature: _____ Date: _____

Cancellation Policy

Dear Patient:

Quite a few patients want to be seen. We know you want to be seen in a timely manner. In order to accomplish this, I schedule the appropriate number of patients to be seen in a set time. That is my responsibility to you. I ask that, in return, you respect my time as well as other patients.

If you cannot keep your appointment, CALL TO CANCEL, 24 hours before your scheduled appointment so that we may schedule another patient for that time. DO NOT send cancellations through email nor to my cell phone. **Please call the** office where your appointment is scheduled. **If we are closed, please leave a message**. All business must function with this understanding.

ALEXANDRIA: 703-549-2626

A $100 charge will be assessed for ALL NO SHOWS (un-cancelled appointments). Fees for un-cancelled appointments will be annotated to your individual invoice with payment expected before your consultation on your next visit. Please honor this policy to avoid unnecessary charges.

I have read the above and I understand that I will be charged **$100** if I fail to cancel my appointments. I also understand that this charge is in addition to any payments.

_____ _____
Signed Date

Notice of Privacy Practice Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1966**

("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice.

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

If you feel your individuals rights, including the right to complain or if you believe your privacy rights have been violated, you may contact the HHS directly.

Patient Name_____ Relationship to Patient:_____
Print

Signature:_____ Date:_____

DOCTOR'S WEIGHT LOSS CENTERS

Weight Loss and/or B-12 Injection Authorization

Patient's Name: _____

Date of Birth: _____

Have you ever received a Weight Loss Injections or Vitamin B 12 shot before?
Yes___ No___ If you answered yes, did you have any adverse reaction? Please explain:

_____

_____

List medication allergies: _____

Authorization for Weight Loss Injections and or Vitamin B 12 Shots

I, _____, have read the above and the benefits and risk of receiving Weight Loss and/or B12 injections. Dr. Heron explained to me and provided a list of side effects and things for me to look out for in regards to these Weight Loss and/or B12 injections. I have agreed to notify Dr Heron if I should have any of these side effects. In addition, I have been able to ask questions that were answered to my satisfaction. I hereby hold Dr Heron's office harmless if I should have a reaction to these Weight Loss and/or B12 injections.

I hereby authorize Dr. Heron's office to give me these weight loss injections weekly and or B12 shots biweekly.

_____ _____
Patients Name Date

_____ _____
Witness Date

Marketing Authorization and Use of Photographs

According to federal law **we must ask for your permission to send to you via email, text, social media or regular mail** information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts, Open House invitations).

Our office DOES NOT SELL or SHARE our patient's names or information.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and **I understand that my health care will not be affected if I do not sign this form.** I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing or email. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I **DO** _____ I **DO NOT** _____ **Please select one**

Authorize Heron Med Spa services or promotions the practice offers. You may choose email, cell phone or both.

I **DO** _____ I **DO NOT** _____ **Please select one**

Authorize Heron Med Spa to use my photographs.

_____

Patient Signature Date

_____

Please Print