NEW PATIENT ENROLLMENT

CONTACT

First Name	Middle Name	Last Name	How did you find out about us?

Home Street Address	Apt. #	City	State	Zip Code

Home Phone	Work Phone	Mobile	Email

We wish to ensure your privacy. In the event that we are unable to reach you, please indicate your preferred methods of contact:

☐ Home Phone ☐Cell Phone ☐ Work Phone ☐E-mail ☐Postal Mail

Emergency Contact Name	Relationship	Emergency Contact Telephone

BIOGRAPHIC

Gender ☐Male ☐Female	Date of Birth(MM/DD/YYYY)	Age	Height ___ft ___inches	Social Security Number - -

Current Weight	Desired Weight (Goal)	Weight 1 Year Ago	Maximum Weight When?

Marital Status ☐Single ☐Married ☐ Divorced ☐Widowed	Occupation (Even if Retired)	Race ☐White ☐African American ☐Hispanic ☐Asian ☐Native American ☐Other_____

TREATMENT

How many Weight Loss Programs have you participated in? Please Name Them:

Please tell us the reasons that you want to lose weight	Do you drink Alcohol? ☐YES ☐NO	Do you smoke Cigarettes? ☐YES ☐NO

Photographs are required for treatment purposes only. Please indicate your consent level for photography:

☐Treatment Only (Strictly Confidential) ☐Treatment & Research

☐Full Consent for Treatment, Research, & Marketing

Are you willing to participate in Testimonials?

☐YES ☐NO

Photography Consent For Treatment Only

I Authorize Transformations Physicians Weight Management medical personnel to take photographs and to use them as an aid in my treatment only. I understand that these photographs will help document the progress of my treatment, and that any photographs taken will remain the property of the facility. I also understand that my identity will be kept strictly confidential.

Patients Initials_____

PRIVACY POLICY

PATIENT ACKNOWLEDGEMENT/CONSENT FORM- Use & Disclosure of Protected Health Information

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you our Privacy Notice that outlines out privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in our Privacy Notice while it is in effect. PLEASE READ OUR PRIVACY NOTICE BEFORE SIGNING.

Our Notice or Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I have received a copy of this office's Notice of Privacy Practices

_____ _____

Signature Date

Payment Policy

I understand that payment for all services will be due at the time Services are rendered, according to the most current Fee Schedule. I agree that should this account be referred to an agency or attorney for collection, I will be responsible for all collections costs, attorney's fees and court costs.

_____ _____

Signature Date