Barbara A. Lubin, MD

Personalized Weight Loss Program

1124 Jenks Ave

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"A goal without a plan is just a wish"

WELCOME TO OUR WEIGHT LOSS PROGRAM

Successful, long-term weight control must focus on your overall health, not just on what you eat. Changing your lifestyle is not easy, but adopting healthy habits may help you manage your weight in the long run. We are honored you have chosen us to supervise your weight loss. Our staff is here to support you in your desire to lose weight.

I, _____ understand that it is my responsibility to:

(Please initial)

_____ Notify the practice of any changes to my address and phone numbers

_____ Notify the practice at least 24 hours in advance of appointment cancellations

Practice policies

- All payments are due at the time of the visit
- Payments can be made by CASH, CHECK, VISA/MASTERCARD/DISCOVER
- $40.00 will be charge for missed appointments that are not cancelled within 24 hours
- $30.00 fee for all returned checks
- Our weight loss program is CASH PAY PROGRAM and we will not file with your insurance
- We DO NOT fill out paperwork for you to attempt to file the visit to insurance

I understand that that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be successful in weight loss.

I have read and understand Barbara A. Lubin, MD LLC policy and agree to be bound by its terms

_____ _____

Patient Signature Date

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____
(Last Name, First Name, Middle Initial)

Social Security: _____-_____-_____ Gender: Male _____ Female _____

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Marital Status: Single_____ Married _____ Divorced _____ Widowed _____ Other _____

Email Address: _____

Employer Name & Phone #: _____

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EMERGENCY CONTACT Name: _____Relation to Patient: _____

Contact Phone: _____

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PHYSICIAN & PHARMACY INFORMATION

Primary Care Physician & Phone: _____
Referring Physician & Phone: _____
Pharmacy Name, Location & Phone: _____

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Are you interested in (please circle one): Weight Loss Vita-Shot

What is your goal weight? _____

_____ _____

Patient Signature Date

PATIENT INTAKE FORM

Name_____ Age_____ (Date) _____

Referring Physician _____
Current weight _____ Current Height _____ Largest weight _____
Current Meal Plan: _____ Meals a day _____ snacks a day _____
Servings of fruits and vegetables a day _____ sodas/sweetened drinks a day in 8 oz servings _____
glasses of water a day _____

Typical Breakfast:
_____
Typical Lunch:
_____
Typical Supper:
_____

Your current activity level on a typical day:
Very Low: Watch TV and little movement

Low: Walk to mailbox, walk around to shop every other day in large store, work full time at desk job.

Medium: Physical job which requires walking more than 50% of the time or exercise for 20 minutes every day by walking/bicycling/dance/swim/other.

High: Very physical job or exercise for more than 30 minutes every day which results in elevated heart rate and inability to have easy conversation.

Current favorite way to fit movement into my life:
_____

Current Health problems I have due to my weight:

- Vascular and Heart Disease- Heart Attacks, strokes, TIAs, blood clots
- Arthritis (Degenerative Joint Disease of knee/hip/back)
- Diabetes Mellitus II
- High Blood Pressure
- High Cholesterol
- Obstructive Sleep Apnea- OSA where I wear a breathing device such as C-PAP to help me breath at night
- Other:_____.

Medication for above stated co-morbidities:
_____
_____
_____
_____

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, (patient/guardian) do hereby authorize Dr. Lubin and staff, to assist me with weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may include the use of appetite suppressants and fat burning injections. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up and show continued weight loss.

To be eligible for appetite suppressants medication, a patient must have a BMI of 30 or above, or a BMI of greater than 27 with at least one comorbidity factory (high BP, High cholesterol, diabetes), or a body fat content equal to or greater than 25% of total body weight for male patients or 30% for women, according to FL State Statute. Once the BMI or body fat content measurement is reduced below these standards, appetite suppressants may not be prescribed. Additional weight loss will be accomplished by following the advised diet, Vita-shots, and exercise until the goal weight is attained Initial: _____

Regarding the use of appetite suppressants, as with any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart rate. I understand that these and other risks could be serious or in rare cases life threatening. Initial: _____

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify Dr. Lubin's staff immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. Initial: _____

I agree not to take any other weight loss medications, other than those prescribed by Dr. Lubin and further agree to inform the staff of ANY changes in my medication or medical history. Initial: _____

I understand that I can be successful without the use of appetite suppressants or injections as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications and injections may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain of the joints, gallbladder disease and even sudden death. Initial:_____

I understand that there is no guarantee that this program will work for me. I understand that I must follow the program as directed in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges are not covered by my insurance and Barbara A. Lubin, MD LLC does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out. Initial: _____

By signing below, I certify that I have read and fully understand this consent form and understand the risks and benefits associated with my treatment for weight loss.

Patient Signature: _____ Date: _____