St. Elizabeth PHYSICIANS
Weight Management Center

Thank you for choosing St. Elizabeth to help you achieve your weight loss goal! This packet will help you prepare for your first visit to get started. If you have not yet scheduled that visit, please call us at 859-212- GOAL (4625). Then review and **complete this packet prior to your first appointment.** Because this information is critical to successfully creating a personalized program for you, if you arrive at your first appointment without a completed packet, your appointment will be rescheduled.

Checklist and survey for your initial visit at the Weight Management Center

- ☐ Did you complete a patient information session? (*Initial and enter date of participation)*
  _____Attended in-person patient information session. *Date attended*: _____
  _____Watched entire online session with Dr. Schumann and Dr. Catanzaro.
  Date viewed: _____

If you have not participated in an in-person or online information session, please note that this free education is required prior to your first visit. It allows us to provide important information to you without charging you for an extensive office visit.

- ☐ After learning about the options during the information session, which program do you feel is right for you? (*Initial your choice below*)
  _____Very Low Calorie Diet (VLCD): meal replacement only program.
  Low Calorie Diet (LCD) (choose option below)
  _____Outlook 1: 1 meal and 2+ meal replacements.
  _____Outlook 2: 2 meals and 1+ meal replacements.
  _____Outlook 3: all food (no meal replacements).
- ☐ I understand the financial and follow-up requirements of the program: (*Circle*) **Yes No**
  - Weekly follow-up initially.
    - If not covered by insurance, $39 self-pay charge for nurse or dietician visit.
  - Meal replacements approximately $3.50 per replacement.
  - If this is not affordable, please discuss with provider at initial visit.
- ☐ Bloodwork is required to enter the program. (*Initial your choice below*)
  _____I prefer to have bloodwork done by my Primary Care Provider.
  _____I prefer to have an order placed at my initial visit.
- ☐ I understand that I will not start the program the day of my initial visit. (*Circle*) **Yes No**
  - VLCD: Program start will be at a one-on-one visit with a nurse/provider.
  - LCD: Program start will be at a new start class with a dietician.

Bring to your visit

- ☐ This checklist.
- ☐ Insurance information.
- ☐ Completed Weight Management Center new patient packet.
  - Received at in-person information session, or
  - Mailed to you after initial visit scheduled, or
  - Printed from stedocs.com/MedicalWeightLossNewPatient.

If you have further questions prior to your visit, please contact us at 859-212-GOAL (4625).

St. Elizabeth PHYSICIANS
Weight Management Center

Dear Patient,

It is with the greatest pleasure that we welcome you to the St. Elizabeth Physicians Weight Management Center. On behalf of our entire weight management team of professionals, we thank you for choosing us and look forward to partnering with you on your weight loss journey.

My name is Dr. Troy Schumann. I have been in family practice for many years in Northern Kentucky and I am the Medical Director for the Weight Management Center. I, along with Dr. Lori Catanzaro and Nurse Practitioner Heather Schuler, are available to help you succeed in your weight loss journey.

It is our mission to provide an evidence-based approach to weight loss and customize an individualized treatment plan for you. We work closely with our experienced, specialized staff of dietitians, behaviorists, nurses and fitness professionals to ensure optimal patient care, safety and outcome.

To expedite your appointment, we have enclosed a health questionnaire and other patient documents that will provide us vital information. We require you to complete this entire packet and bring it to your first appointment. This will provide the information we need to create a personalized weight management solution for you.

Out of respect for all our patients, providers and associates we require at least a 24-hour notice to cancel or change an appointment. If you have any questions, please feel free to call us at 859-212-GOAL (4625).

Thank you for your trust in us. We look forward to working with you on this important decision you've made to live a healthier life.

Sincerely,

Dr. Troy Schumann, Medical Director
Dr. Lori Catanzaro, Bariatrician
Heather Schuler, Nurse Practitioner

St. Elizabeth PHYSICIANS
Weight Management Center

St. Elizabeth Physicians Weight Management Center
Locations and Directions

Florence, Kentucky

1. Located at St. Elizabeth Florence, 4900 Houston Rd.
2. Park in the Outpatient area of the hospital in the Zone 3 Lot (Green).
3. Enter the hospital at 3A and enter through the sliding glass doors.
4. Turn left toward the Vascular Department and follow the hallway.
5. We are located just beyond the Vascular Department at the end of the hallway

Ft. Thomas, Kentucky

1. Located at 1400 North Grand Avenue.
2. Turn right at the traffic light into the driveway to St. Elizabeth Medical Pavilion.
3. Park in the Outpatient parking lot in front of the building.
4. Go to the Main Entrance and enter through the sliding glass doors.
5. Turn Left toward Heart and Vascular and continue down the hall to Weight Management. Reception desk is on the right side of the hallway.

Greendale, Indiana

1. Located at St. Elizabeth Greendale, 1640 Flossie Dr.
2. Take I-275 West or East to Lawrenceburg Aurora Exit #16.
3. Turn right off the exit ramp to Rt. 50.
4. Turn right into St. Elizabeth Greendale.

Phone: (859) 212-GOAL (4625)

St. Elizabeth PHYSICIANS

PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security # ____-____-_____ Last Name _____ First Name _____ Middle ____

Address_____ City _____ St ____ Zip _____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)____-_____

Emergency Contact _____ Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

Pharmacy most used by patient _____Pharm. Phone (____) ____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security # ____-____-_____ Name _____

Address _____ City _____ St ____ Zip_____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)_____-_____

Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

PRIMARY INSURANCE COMPANY NAME_____ **No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ PCP _____ Copay _____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ Copay _____

I understand that I am responsible for payment for all services rendered. I hereby assign, and authorize direct payment of my medical benefits to St. Elizabeth Physicians. However, I understand and agree to pay all charges or amounts not timely paid by my insurance policy or plan including, but not limited to, any co-pays or deductibles. I acknowledge that it is my responsibility to know and understand the terms of my insurance policy or plan. I authorize St. Elizabeth Physicians to release all of my medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits, to authorize medical services to be received, to process claims for benefits, to represent me in a third-party payer's hearing or appeal process, and/or to collect any payments. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. In accordance with recognized coding standards, I understand that I may receive separate charges for procedures, physicals and/or other problem-oriented treatment during a single visit.

I further authorize the access and release of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers involved in my care.

I give my consent to St. Elizabeth Physicians to provide medical care and treatment to me as deemed necessary and proper by my physician. I authorize St. Elizabeth Physicians billing or my provider's office to contact me by my cell phone. _____YES _____NO

Signature X_____ Date _____
(Signature of patient or patient representative)

Witness _____

St. Elizabeth PHYSICIANS

Receipt of Notice of Privacy Practices
ALTERNATE COMMUNICATION REQUEST FORM

Patient Name _____ Date of Birth _____/_____/_____
(Print full name)

I wish to be contacted in the following manner (check all that apply):

☐ By home, cell or work phone listed in my registration as below.

Home	Cell	Work		Other
☐	☐	☐	O.K. to leave message on voice mail	_____
☐	☐	☐	O.K. to leave message with individual	_____
☐	☐	☐	Leave message with call-back number only	_____
☐	☐	☐	Do not leave message	_____

☐ Written Communication

☐ O.K. to mail to my home address ☐ O.K. to fax to this number _____

☐ O.K. to mail to my work/office address ☐ O.K. to e-mail to address listed in my registration

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I, _____ give permission to the following individuals to obtain the indicated
(Name of Patient or Responsible Party)
information:

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ Prescription refills on my behalf
_____ Test results on my behalf
_____ Set up appointment/ or cancel on my behalf
_____ Speak to the doctor/MA either in person or by telephone on my behalf
_____ Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID.

Effective Date _____ Expires _____ Revoked _____

It is the responsibility of the patient to notify the physician's office if there is a change in this information.
*****Scan original in chart, copy may be given to patient*****

By signing this waiver I release St. Elizabeth Physicians and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of St. Elizabeth Physicians ***Notice of Privacy Practices****. The effective date of the notice is*: 9/23/2013

Signature of patient or responsible person _____

Relationship of Representative to Patient _____ Date _____

Signature of witness _____ Date _____

Health History Questionnaire

Name: _____ **Date of Birth:** ____/____/____ **Age:** _____

Gender: ☐ M ☐ F
Race: ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ American Indian
☐ Black or African American ☐ Alaska Native ☐ Unknown

Present Status

Are you in good health at the present time to the best of your knowledge? ☐No ☐Yes
If no, please explain. _____

_____

_____

Are you under a doctor's care at the present time? ☐No ☐Yes
If yes, whom and for what? _____

_____

_____

Are you taking any medications at the present time? ☐No ☐Yes
***Prescription Drugs*: List all**

Drug:	**Dosage:**

***Over-the-Counter medications, vitamins, supplements*: List all**

Product/Dosage	**Product/Dosage**

History of Frequent Headaches or Migraines? ☐No ☐Yes
Medication: _____

Allergies

Are you allergic to latex? ☐**No** ☐**Yes**
Are you allergic to medications? ☐**No** ☐**Yes**
If yes, please list:

_____ _____

_____ _____

_____ _____

Serious Injuries

Specify (list all including date)

_____ _____

_____ _____

_____ _____

Previous Bariatric Surgery

Type: _____

Date: _____ Surgeon:_____

Original Weight _____ lbs Lowest Weight Achieved _____ lbs

Were there any complications? Please list:_____

_____

_____

Non-Bariatric Surgical History

Specify (list all including date)

_____ _____

_____ _____

_____ _____

Family History

	Age	Health	Disease	Cause of Death	Overweight Y/N
Father					
Mother					
Brothers					
Sisters					

Gynecologic History

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset _____ **Are they regular:** ☐No ☐Yes

Duration _____ **Pain associated:** ☐No ☐Yes

Last menstrual period: _____ **History of PCOS** ☐No ☐Yes

Hormone Replacement Therapy: ☐No ☐Yes

Type: _____

Birth Control Pills: ☐No ☐Yes

Type: _____

Last Check Up Date: _____

Patient Name:_____ Date of Birth:_____

Medical History

Please check if you or a family member has a history of any of the following conditions:

Condition	Self	Family	Condition	Self	Family
Anemia			Kidney Disease		
Arthritis			Kidney Stones		
Asthma			Liver Disease / Hepatitis		
Blood Clots/ Clotting Difficulty			Malaria		
Previous Blood Transfusions			Measles/ Mumps		
Cancer			Mental Health Issues		
Chicken Pox			Migraine Headaches		
Chronic Cough / Bronchitis			Muscle Weakness or Pain		
Constipation			Nervous Breakdown		
Depression			Osteoporosis		
Diabetes			Pleurisy		
Diarrhea			Pneumonia		
Drug Abuse			Polio		
Eating Disorder			PCOS		
Epilepsy / Seizures			Previous Blood Transfusions		
Gallbladder Disease			Rheumatic Fever		
Glaucoma			Scarlet Fever		
Gout			Sleep Apnea		
Heart Disease			Snoring		
Congestive Heart Failure			Stroke / TIA		
Heart Valve Disorder			Swelling in feet or legs		
Stents			Stomach Problems/ GERD/ Ulcers		
Heart Surgeries			Urinary Incontinence		
Murmur			Tonsillitis		
Arrhythmias (A-fibrillation)			Tuberculosis		
Angina / Chest Pain			Thyroid Problems		
High Blood Pressure			Whooping Cough		
High Cholesterol			Wounds		
			Other		

Please indicate if you have any of the following problems/concerns:

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Weight loss
☐ Weight gain
☐ Chewing problems
☐ Swallowing problems
☐ Change in appetite
☐ Other_____

Patient Name:_____ Date of Birth:_____

Nutrition History

Gender: _____ **Height:** _____ **Weight:** _____ **Current Weight:** _____
Desired Weight: _____ (What is the weight you would like to be?)
Occupation: _____ **Work Schedule:** ☐ Day Shift ☐ Night Shift
☐ Weekdays ☐ Weekends ☐ Traveling: _____

Please indicate if you follow a special diet:
☐Carbohydrate restricted ☐Fat restricted ☐Vegetarian ☐Salt restricted ☐Calorie restricted
☐Low Cholesterol ☐Other _____

Are you currently following that diet? ☐No ☐Yes (please explain)

_____

If you follow a special diet, who recommended it and why? (i.e. physician, self, friend)

_____

Food Cravings: ☐No ☐Yes (please explain) _____
Any specific time of the day or month that you crave food? _____
Religious or Cultural Food Requests ☐No ☐Yes (please explain) _____

Food Preferences: Do you avoid any food?

_____

Do you have any food allergies? ☐No ☐Yes (please list)

_____
Have you experienced a significant change in weight?" ☐No ☐Yes **If yes, what are your perceived reasons for weight gain or weight loss?**

_____

Have you tried to lose weight before?: ☐No ☐Yes (how many times) _____
If yes, what is the main reason for your decision to lose weight? _____
Do you have a good support system with your weight loss efforts? _____

Body Weight History: Highest Weight _____ When _____
Lowest Weight _____ When _____
Usual Weight _____ When _____
Birth Weight _____ Weight at 20 years old _____

Have you ever tried any of the following for weight control? If yes, did you have success?

Jenny Craig/ Weight Watchers/ Nutrisystem	☐No	☐Yes	_____	Date _____
Liquid diets (Optifast/Nutrimed/New Direction)	☐No	☐Yes	_____	Date _____
Meal Replacements (Lean Cuisine, Slim Fast)	☐No	☐Yes	_____	Date _____
Low carbohydrate (Atkins/South Beach)	☐No	☐Yes	_____	Date _____
Fad diets	☐No	☐Yes	_____	Date _____
Prescription diet pills	☐No	☐Yes	_____	Date _____
Over the counter diet pills	☐No	☐Yes	_____	Date _____
Laxatives/ Diuretics/ Vomiting	☐No	☐Yes	_____	Date _____
Excessive exercising	☐No	☐Yes	_____	Date _____
Self-designed program/ Other	☐No	☐Yes	_____	Date _____

Comments: _____

Patient Name:_____ Date of Birth:_____

Eating Habits

Do you skip meals? □No □Yes
How many days per week do you eat: **Breakfast** _____ **Lunch** _____ **Dinner** _____

Please list the times of day and the foods you typically eat at each meal

	Time of Day	Foods Typically Eaten
Breakfast		
Lunch		
Dinner		
Snack		

Do the weekends affect your eating habits? □No □Yes (please explain)
_____

Do you snack? □No □Yes If yes, on what types of food do you snack? _____
What time of the day do you snack? _____
Is it a planned snack? □No (please explain) _____ □Yes

What do you add to your food at the table? □Salt □Salt substitute □Sugar □Sugar substitute
□Butter □Margarine □Other _____

Who does the meal planning? □Self □Significant Other □Both □Other _____
Who does the grocery shopping? □Self □Significant Other □Both □Other _____
What day and what time of the day do you shop? _____
With whom do you live? _____
Is your spouse, fiancée or partner overweight? □No □Yes If Yes, how much overweight? _____
Who prepares the food at home? □Self □Significant Other □Both □Other _____
What is the skill level? _____
Does this person enjoy cooking? _____
Is salt added during cooking? □No □Yes
Do you eat meals outside of the home? □No □Yes **How many meals per week?** _____
How many meals per week do you eat out for: breakfast _____ lunch_____ dinner_____
What restaurants do you usually choose? (Please list) 1._____ 2._____
3._____ 4. _____ 5. _____ 6. _____
Do you read food labels? □No □Yes What do you look at on the label?
_____

Do the nutrition facts on the label influence your decision to eat the food or drink the item?	□No □Yes
Do you eat in the car?	□No □Yes
Do you eat standing up?	□No □Yes
Do you eat while watching TV?	□No □Yes
Do you eat while reading or on the computer?	□No □Yes
Do you eat with others?	□No □Yes
Do you eat fast?	□No □Yes
Do you eat when bored?	□No □Yes
Do you eat when stressed?	□No □Yes
Do you eat when you are anxious?	□No □Yes
Do you eat when you are lonely?	□No □Yes
Do you eat when you are hungry?	□No □Yes
Do you eat when you are <u>not</u> hungry?	□No □Yes
Do you awaken hungry during the night?	□No □Yes (If yes, what do you do? _____)

Patient Name:_____ Date of Birth:_____

Do you think that you are currently undergoing a stressful situation or an emotional upset?
□No □Yes If yes, please explain _____

Are there some foods you find it impossible to stop eating once you start?	□No □Yes
Do you tend to clean your plate even if you are full before the meal is over?	□No □Yes
Do you use food as a reward or to get energy when you feel tired?	□No □Yes
Do you gulp or inhale your food so that you barely taste it?	□No □Yes
Do you feel that sometimes your eating is sometimes out of control and you can't seem to change it?	□No □Yes
If you are on a diet and eat a food that is not allowed, will you eat more or less for the rest of the day	□More □Less
Do you feel that you eat significantly less than others do and still gain weight?	□No □Yes
Is income a factor in your selection of food?	□No □Yes

What types of beverages do you usually drink? How many servings of each do you drink in a day?

Beverage Type	**Number of servings per day**
□Water	
□Juice: (please check) □regular juice □diet juice	
□Soda: (please check) □regular soda □diet soda □caffeine free soda	
□Iced tea: (please check) □sweet tea □diet tea □green tea □caffeine free tea	
□Milk:(please check) □whole milk □2 % milk □1% milk □skim milk	
□Coffee: (please check) □regular □decaffeinated □cappuccino □non-dairy creamer □half and half □sugar	
□Alcohol: (please check) □beer □wine □hard liquor	

Please list any specific questions or concerns that you may have regarding nutrition:

_____
_____
_____

What, if any, expectations do you have coming to see the dietitian here?

_____
_____
_____

Smoking Habits

Answer only one:

□You have never smoked cigarettes, cigars or a pipe.
□You quit smoking ____years ago and have not smoked since.
□You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
□You smoke 20 cigarettes per day (1 pack).
□You smoke 30 cigarettes per day (1-1/2 packs).
□You smoke 40 cigarettes per day (2 packs).

Patient Name:_____ Date of Birth:_____

Activity Level

Answer only one:

- □ Inactive—no regular physical activity with a sit-down job.
- □ Light activity—no organized physical activity during leisure time.
- □ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- □ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
- □ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior Style

- □ You are always calm and easygoing.
- □ You are usually calm and easygoing.
- □ You are sometimes calm with frequent impatience.
- □ You are seldom calm and persistently driving for advancement.
- □ You are never calm and have overwhelming ambition.
- □ You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make:

_____

_____

_____

Functional/Educational/Psychosocial History

Are you able to read and write? □No □Yes
What is your highest level of education? _____
How do you learn best? □Reading □Watching □Talking □Practicing
Do you have any limitations to learning? □No □Yes
If yes please explain: _____
Do you have a learning disability? □No □Yes
If yes please explain: _____
Do you speak and understand English? □No □Yes
If no, what is you primary language? _____
Do you have any hearing loss? □No □Yes
If yes please explain: _____
Do you have any vision loss? □No □Yes
If yes please explain: _____
Do you have any speech limitations? □No □Yes
If yes please explain: _____
Do you have any physical limitations? □No □Yes
If yes, what limitations do you have? _____
Are you able to get in/out of a chair/bed? □No □Yes
Do you have any special religious/cultural needs? □No □Yes
Are you able to perform the activities of daily living? □No □Yes

Pain Assessment

Are you having pain now or have you experienced pain in the recent past several weeks? ☐ No ☐ Yes
If you answered yes above, will your pain interfere with your visit today? ☐ No ☐ Yes
Can we assist you with your pain with a list of community resources? ☐ No ☐ Yes
Resource list given? ☐ No ☐ Yes

This information will assist us in assessing your particular problem areas and establishing your medical management.
Thank you for your time and patience in completing this form.

Patient Name:_____ Date of Birth:_____

Food and Activity Log Instructions:
PLEASE COMPLETE 4 DAYS OF TRACKING

Meal or Snack: Indicate the type of eating with the appropriate letter, either M for meal or S for snack.

Time spent eating: Record the amount of time spent eating the meal or snack.

Starting time: Include the time the meal or snack began.

Food eaten and how it was prepared: If space allows, include cooking method, added fats, oils, or sugar, and condiments. Please indicate the cut of meat if possible.

Amount eaten: Estimate the amount of food eaten. If you can, indicate the amount in teaspoons, tablespoons, cups, ounces, or pounds, but if you don't know these, try to compare the size of the food portion to a common household item such as a light bulb or a deck of cards.

Hunger: On a scale of 0 to 5, rate how hungry you were when you ate the meal or snack, with 0 being "not hungry" and 5 being "extremely hungry".

Reason/Mood: Note your mood and the emotional reasons which may have caused you to eat. If there are none, write "none".

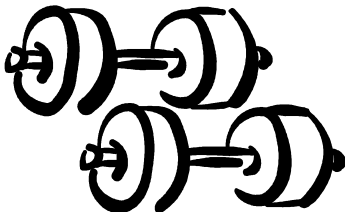
Location: Where were you when you ate? If you were at home, what room were you in? Were you on the couch? In bed?

Eating position: Indicate whether you were 1 – walking, 2- standing, 3 – sitting, or 4 – lying down.

With whom: Were you eating with anyone else? Whom?

Doing what: Were you doing something else while you ate such as checking Email, watching TV, or reading a book?

Type of exercise and how long: Record daily exercise as specifically as possible. "Walked over 1 mile of flat ground at a moderate pace" is more specific than "Took a walk."



Patient Food and Activity Log

Name _____ Date_____

Meal or Snack? Time spent eating Starting time	Food eaten and how it was prepared, including condiments	Amount eaten	Hunger 0 = none 5= very	Reason/ Mood	Location, Eating position, With whom, Doing what	Type of exercise and how long
Example M, 15 minutes, 6:45 AM	*Quaker oats prepared with 1% milk and 1 t brown sugar, OJ, banana*	*¾ cup oat. 1 c OJ Med banana*	*4*	*Hungry*	*Kitchen, 2 and 3, alone, packing lunch*	

Patient Health Questionnaire (PHQ)

This questionnaire is an important part of providing you with the best healthcare possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name _____Age_____ Sex ◯ Female ◯ Male Today's Date _____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	◯	◯	◯
b. Back pain	◯	◯	◯
c. Pain in your arms, legs, or joints (knees, hips, etc.)	◯	◯	◯
d. Menstrual cramps or other problems with your periods	◯	◯	◯
e. Pain or problems during sexual intercourse	◯	◯	◯
f. Headaches	◯	◯	◯
g. Chest pain	◯	◯	◯
h. Dizziness	◯	◯	◯
i. Fainting spells	◯	◯	◯
j. Feeling your heart pound or race	◯	◯	◯
k. Shortness of breath	◯	◯	◯
l. Constipation, loose bowels, or diarrhea	◯	◯	◯
m. Nausea, gas or indigestion	◯	◯	◯

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Some days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	◯	◯	◯	◯
b. Feeling down, depressed, or hopeless	◯	◯	◯	◯
c. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
d. Feeling tired or having little energy	◯	◯	◯	◯
e. Poor appetite or overeating	◯	◯	◯	◯
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
g. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
h. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
i. Thoughts that you would be better off dead or off hurting yourself in some way	◯	◯	◯	◯

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate boil explanation. Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all). Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all) PHQ1/3

3. Questions about anxiety	No	Yes
a. In the last 4 weeks, have you had an anxiety attack, suddenly feeling fear or panic? **IF YOU CHECKED "NO", GO TO QUESTION #5**	◯	◯
b. Has this ever happened before	◯	◯
c. Do some of these attacks come suddenly out of the blue, that is, in situations where you don't expect to be nervous or uncomfortable	◯	◯
d. Do these attacks bother you a lot or are you worried about having another attack?	◯	◯

4. Think about your last bad anxiety attack	No	Yes
a. Were you short of breath	◯	◯
b. Did you heart race, pound, or skip	◯	◯
c. Did you have chest pain or pressure	◯	◯
d. Did you sweat	◯	◯
e. Did you feel as if you were choking	◯	◯
f. Did you have hot flashes or chills	◯	◯
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea	◯	◯
h. Did you feel dizzy, unsteady or faint	◯	◯
i. Did you have tingling or numbness in parts of your body	◯	◯
j. Did you tremble or shake	◯	◯
k. Were you afraid you were dying	◯	◯

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?	Not at all	Some days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things **IF YOU CHECKED "NOT AT ALL", GO TO QUESTION #6**	◯	◯	◯
b. Feeling restless so that it is hard to sit still	◯	◯	◯
c. Getting tired very easily	◯	◯	◯
d. Muscle tension, aches, or soreness	◯	◯	◯
e. Trouble falling asleep or staying asleep	◯	◯	◯
f. Trouble concentrating on things, such as reading a book or watching TV	◯	◯	◯
g. Becoming easily annoyed or irritable	◯	◯	◯

FOR OFFICE CODING: Pan Syn if all #3a-d are "Yes" and four of more of #4a-k are "Yes". Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

6. Questions about eating	No	Yes
a. Do you often feel that you can't control what or how much you eat	◯	◯
b. Do you often eat, within any 2 hour period, what most people would regard as an unusually large amount of food **IF YOU CHECKED "NO" TO EITHER #a OR #b, GO TO QUESTION #9**	◯	◯
c. Has this been as often, on average, as twice a week for the last 3 months	◯	◯

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	No	Yes
a. Made yourself vomit	◯	◯
b. Took more than twice the recommended dose of laxatives	◯	◯
c. Fasted- not eaten anything at all for at least 24 hours	◯	◯
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating	◯	◯

8. If you checked "Yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	No	Yes
	◯	◯

9. Do you ever drink alcohol (including beer or wine)? **IF YOU CHECKED "NO" GO TO QUESTION #11**	No	Yes
	◯	◯

10. Have any of the following happened to you more than once in the last 6 months?	No	Yes
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	◯	◯
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	◯	◯
c. You missed or were late for work, school, or other activities because you were drinking or hung over	◯	◯
d. You had a problem getting along with other people while you were drinking	◯	◯
e. You drove a car after having several drinks or after drinking too much	◯	◯

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
◯	◯	◯	◯

FOR OFFICE CODING: But Ner if #6a,b and c and #8 are all "Yes", Bin Eat Dis the same but #8 either "No" or left blank. Afc Abu if any of #10a-e is "Yes".

 PHQ3/3

Dear Patient,

Prior to your first visit with a Registered Dietitian at the Weight Management Center, please contact your insurance company to determine if your plan cover charges for a Registered Dietitian visit for Medical Nutrition Therapy in a medically supervised weight loss program. Specifically, verify coverage for the following codes:

Visit code 97802 or 97803 using a diagnosis of:

Overweight	**(E66.3)**
Obesity	**(E66.9, E66.0, E66.09, E66.8)**
Obesity, extreme or morbid	**(E66.01)**

If you do have coverage available, ask how many visits are covered per year and what percentage of the charge is covered. This will help you determine what your weekly cost will be while in the program.

Medical Weight Loss Programs

Welcome to St. Elizabeth Physicians Weight Management Center! By attending this information session, you will learn how to improve your health and quality of life while losing weight quickly and safely under the direct supervision of our physician and medical weight loss team of professionals. It is our mission to provide you with an evidence-based approach to weight loss and weight maintenance through an individualized treatment plan designed to meet your needs and goals.

Our Comprehensive Weight Management Team:
Bariatricians (Physician specializing in treatment of obesity)
Registered Dietitians
Registered Nurses and Nurse Practitioner
Behavioral Health Therapists
Medical Assistants
Front Office Support Staff

Your Plan:
Bariatricians, Dr. Troy Schumann and Dr. Lori Catanzaro and our team of professionals will customize a weight loss and weight maintenance plan just for you.

Very Low Calorie Diet (VLCD)
The New Direction® VCLD is a medically-supervised rapid weight loss program designed for individuals who have at least 40 pounds to lose, have a Body Mass Index (BMI) ≥30, or have health risks, which could improve from weight loss. It combines a very low-calorie diet with close medical monitoring, counseling and education.
During this time of rapid weight loss referred to as the Reducing phase, New Direction® products will be your only source of nutrition. You will be monitored weekly by a registered nurse and monthly by the bariatrician. Labs are typically repeated at one week (BMP) and then monthly (CMP). EKG's are repeated at each 50 pounds of weight loss.
As you approach your weight goal, you will enter the Adapting phase and gradually decrease the use of products and begin to add more food to your daily diet. Now you will begin weekly visits alternating group education classes and individual counseling visits with a registered dietitian that will ensure optimal nutrition, meal planning, and behavior changes. The goal here is to give you insight into your eating and activity habits so you can permanently alter your lifestyle to achieve lasting weight control and better health.

Quick Start VLCD
This option starts you on the VLCD as described previously for the first 4 weeks. At that time, you will be reassessed by the Bariatrician and can transition to a Low Calorie Diet (LCD) if desired. This allows you the benefit of 4 weeks of very rapid weight loss to get started, while knowing you can return to some food on a LCD plan. You may also remain on the VLCD if desired as well.

Medical Weight Loss Programs

Contraindications for New Direction® VLCD Only
Age < 18 years
Metastatic cancer
Bone fractures
Corticosteroid therapy
Type I Diabetes (on insulin)
Endocrinologic cause of obesity
Peptic ulcer disease, active gastritis or duodenal ulcers
Heart attack within the last three months
Hyperuricemia, untreated
Kidney disease (renal insufficiency)
Inflammatory bowel disease, untreated
Lithium treatment
Liver disease, requiring protein restriction
Mental retardation
Untreated mental illness
Pregnancy
Sensitivity to aspartame or allergy to milk proteins, soy
Treatment with phenothiazines

Low Calorie Diet (LCD)
The LCD is designed for individuals with 10 pounds or more to lose. It can combine New Direction® meal replacements along with traditional menu planning of select meals to assist in providing steady weight loss. Each LCD is organized around nutrition, behavior and exercise goals, to help participants lose weight safely and effectively- and to maintain your healthy new weight. Just as the Adapting phase of the VCLD, you too will benefit from weekly alternating group education classes and individual counseling visits with a registered dietitian. You will see the bariatrician initially after 4 weeks, and then bi-monthly to assess your progress and optimize your weight loss.

New Direction® Meal Replacements:
New Direction® meal replacements, taken as medically prescribed by our bariatrician are designed to be nutritionally adequate, providing 100% of the RDI's for vitamins and minerals.

- √ High protein, low carbohydrate, low sugar
- √ Most products are gluten free
- √ Aspartame free products
- √ Low in lactose (equivalent to 1 cup of milk)
- √ All products are made with milk

Medical Weight Loss Programs

Weight Loss Expectations:
Several factors including your current weight, gender and age will affect your weight loss. On a VLCD, an average weight loss of 4-7 pounds is common in the first week, with water accounting for many of these pounds. After the first week, the rate of weight loss decreases to about 2 to 3 pounds per week on average. On the LCD, you may lose more than two pounds in the first week when you first begin the reducing phase, again some attributed to water. The weight loss continues, but at a slower rate averaging 1 to 2 pounds per week.

Patient Process:
Step One: Mandatory Information Session
Program overview, fee schedule, and patient forms are provided. You will have an opportunity to schedule an appointment with the Bariatrician to begin your program afterwards. Mandatory labs and possibly EKG must be completed and reviewed by Dr. Schumann prior to your beginning a program.

Step Two: Blood work and EKG
These may be completed prior to Bariatrician visit if your Primary Care Physician orders them. Dr. Schumann/Dr. Catanzaro can order these as well during your initial consultation. Results must be reviewed before clearance to begin program.

Step Three: Bariatrician visit
A thorough history and physical exam are conducted, assessment of test results is completed, and a customized weight loss plan is prescribed designed to fit your individual needs and goals. A body composition and measurements will be taken. These will be repeated every 8-12 weeks to compare with previous measurements as another way to measure success with your weight loss journey.

New patient packet including food diary must be COMPLETELY filled out prior to arrival and turned in at your initial MD visit.

Step Four: Patient "New Start" Orientation Class or appointment
Program explanation and expectations, product information, consent review and signing; and if LCD, meal planning information to get you started. Meal replacement distribution is provided at conclusion to begin your program. You must be cleared by the bariatrician before you attend this session.

IF VLCD:

Step Five (VLCD): "Reducing" phase- *(see below for LCD steps)*
VLCD: Careful, medical monitoring by staff to ensure safety during the "Reducing" phase. Your caloric intake is significantly reduced to promote rapid weight loss. You must have weekly assessments with a registered nurse and monthly assessments with our Bariatricians. Mandatory, routine lab work is ordered periodically to monitor your body's response. You will receive product at your weekly visits.

Step Six (VLCD): Behavioral Health Assessment
All patients will have an assessment with our Behavioral Health team within weeks 4-6 after starting your program.

Step Seven (VLCD): "Adapting" phase
When you are nearing your weight goal, you will begin the "Adapting" phase. You will begin to introduce foods back into your diet during this critical phase under the direction of your registered dietitian. The "Adapting" phase typically involves 3-4 weekly appointments with the dietitian to give you the skills necessary to successfully reintroduce food back into your daily meal plan, followed by meeting with the bariatrician. Then you will alternate weekly appointments between group education classes and your dietitian. Weekly visits are critical during this phase. You will continue to receive meal replacements at your weekly visits. You will now see the bariatrician every 8 weeks instead of monthly. The visit prior to this you will see the nurse to have your body composition and measurements taken.

Step Eight (VLCD): "Sustaining" phase
Lastly, you will move to the "Sustaining" phase when you have reached goal. You are eating regular foods and practicing your new lifestyle and weight management skills. You will continue to work with your dietitian monthly and see your bariatrician every 6 months. Education classes may be repeated as desired. You may continue limited meal replacements if desired under the supervision of our team. Continuing your commitment to maintain your healthy new weight at this phase is essential to your long-term success.

IF LCD:

Step Five (LCD): "Reducing" phase
Several pathways are available based on your individual needs. The "Reducing" phase is typically a combination of New Direction® meal replacements and pre-planned meals. For example, you may drink 1-2 New Direction® beverages; eat one meal, and perhaps a snack. Additionally, you may opt out of meal replacements all together and proceed through LCD program. This is completely individualized for each patient.

Step Six (LCD): Nutrition Assessment
To optimize success, you will have an assessment within 7 days of your New Start with a registered dietitian. You will then alternate weekly visits between group education classes and counseling visits with your registered dietitian. You will see the bariatrician 4 weeks after starting your program, then every 8 weeks. The visit prior to this you will see the nurse to have your body composition and measurements taken. Weekly visits are mandatory. You will receive meal replacements at your weekly visits.

Step Seven (LCD): Behavioral Health Assessment
All patients will have an assessment with our Behavioral Health team within weeks 4-6 after starting your program.

Medical Weight Loss Programs

Step Eight (LCD): "Adapting" phase
When you are nearing your weight goal, you will enter the "Adapting" phase where you will gradually decrease the use of meal replacements and return to eating regular meals. You will continue weekly visits by attending classes and working with your registered dietitian bi-weekly through this critical transition phase.

Step Nine (LCD): "Sustaining" phase
Lastly, you will move to the "Sustaining" phase when you have reached goal. You are eating regular foods and practicing your new lifestyle and weight management skills. You will continue to work with your dietitian monthly and see your bariatrician every 6 months. Education classes may be repeated as desired. You may continue limited meal replacements if desired under the supervision of our team. Continuing your commitment to maintain your healthy new weight at this phase is essential to your long-term success.

Group Education Classes:
Group education classes (mandatory for LCD/Adapting patients) are designed to ensure optimal success in your weight loss journey. The classes offer a variety of topics targeting nutrition and behavioral health to help you develop the tools necessary to achieve your weight loss goals as well as maintain that loss long term. There are several classes held weekly for your convenience.

****You must sign-up ahead of time for all classes****

Class Schedule

	Tuesday	**Thursday**
Florence	9 am (fourth week) LCD New Start Orientation class 10:00 am (every other week) Information session 12:00 pm Group Education class 4:30 pm Information Session 6:00 pm Group Education class	6:00 pm LCD New Start Orientation
Fort Thomas	5:00 pm Group education class	

Medical Weight Loss Programs

Program Costs

St. Elizabeth Physicians Weight Management Center's Medical Weight Loss Programs are physician-supervised and professionally staffed by a team of specialists and evidence-based to ensure that you have the tools that you need to be successful long-term in a safe and supportive environment.

Consider the emotional and monetary investment that you have made with past diet attempts. Now consider the value of this as an investment in a healthier future for yourself. Consider you may significantly reduce your monthly cost of medications and medical care when you improve chronic health conditions, and reduce or eliminate the need for medications for diseases such as hypertension, diabetes and high cholesterol.

Actual charges for services and meal replacements as part of your weight loss plan may vary, as plans are individualized for our patients. However, normal charges are listed on the following page for general reference.

We will attempt to verify your insurance benefits for specific coverages such as physician, behavioral health and dietitian services (Medical Nutrition Therapy). If billable charges are covered, we will file these to your insurance for you. Otherwise, full payment is due at time of service for non-billable/non-covered fees including meal replacement purchases. If there are coverage exclusions on billable charges, there is a discount available on these billable fees only. Fees excluded by your insurance are also due at time of service at the discounted price.

Please note that weekly R.N. counseling visits (VLCD), mandatory educational classes (for LCD) and any meal replacement purchases are <u>never</u> billable to insurance under our weight management programs. These fees are always due from the patient at the time of service. The R.N. visit, education classes and any billable services not covered by your plan may be covered under a flexible spending/Health Savings account if you have one. Products may also be covered; however you should consult your FSA/HSA administrator for confirmation. We can provide a letter of medical necessity to support if requested.

Medical Weight Loss Programs

Fee Schedule	**Billed Charge**	**Discounted self-pay price**
Initial physician H&P	$168-$324	$118-$227
Follow-up physician visit	$114-$226	$80-$158
Initial Dietitian Assessment	$296	$41
Follow-up Dietitian	$128	$39
Initial BH Assessment	$279	$195

Non-billable Program Charges	**Patient fee due at time of service**
R.N. weekly visit (VLCD)	$39
Class fee for LCD & Adapting patients (When mandatory attendance required)	$20**

***Optional discounted $100 class series price -- non-refundable and paid in full at the time of the first class (7 classes for price of 5)*

New Direction® Meal Replacements (box of 7 packets) $23**

***10% discount for LCD's on 1 week supply of meal replacements applied on the weeks class is attended*

ie: 600 calories/day = 3 packets/day or 3 boxes/week = $69/week product cost
ie: 800 calories/day = 4 packets/day or 4 boxes/week = $92/week product cost

Lab/EKG fees: (if insurance does NOT cover)

CBC w/diff.	$37.14	HgA1c	$46.34
CMP	$40.15	Fasting Insulin	$54.57
TSH	$80.26	Uric Acid	$21.56
T3	$80.89	Magnesium	$31.99
T4	$43.05	Vitamin D	$183.86
Lipid Panel	$54.36	Blood draw fee	$10.50

VLCD - add EKG: $125.00 **this will also generate a physician charge from the Cardiologist for reading the results-billed separately.*

Standard Start-up Testing: Lab tests ($700) + EKG ($125) = $825
(If not covered by insurance, self-pay discount would apply)
Self pay discounted price = $438

****All prices are subject to change****

Medical Weight Loss Programs

Lab fees:

Week 2: BMP $32.24 +Draw fee $10.50 (VLCD only)
Self pay discounted price: $ 22.65

Recurring Lab: CMP $40.15+Draw $10.50 (Monthly for VLCD only)
Self pay discounted price: $27

Attendance Policy:

- Patients are required to attend their weekly prescribed visit/class during the Reducing and Adapting phases.

- Patients are expected to **ARRIVE** at time instructed for that specific visit or class which is usually 20 minutes before the actual appointment/class time in order to complete check-in processes. **This is critical in order for patient to be ready for provider to see them at their scheduled appointment time. Medical intake/measurements are done during this time.**

- Patients arriving more than 5 minutes past the instructed **ARRIVAL** time may be asked to reschedule a make-up session at an additional fee.

- During the Reducing and Adapting phases, patients will be allowed to miss no more than three weekly visits or classes in four months. A patient missing more than this may be dismissed from program as close supervision is an essential element of the program structure.

- **At least 24 hour advance notice** must be given to Center if patient must cancel or change their scheduled visit or class. Rescheduling will be subject to provider availability. Dismissal from practice may occur if patient misses 3 appointments without giving proper 24 hours+ advance notice.

- Patients should notify appropriate clinical staff at least two weeks prior to vacation so that arrangements can be made for appropriate counseling and meal replacement supply and to cancel any appointments they will not be attending. Patients can request a one-time leave of absence if a situation arises that may prohibit their attendance for a prolonged period of time.

On behalf of the St. Elizabeth Physicians Weight Management Center team, thank you for your time today. We are looking forward to a building a life-long partnership to assist you on your journey to a healthier weight and lifestyle. If you have further questions or would like to schedule an appointment, please contact us at **(859) 212-GOAL (4625)**.

Patient forms are available for download from our website at

http://www.stedocs.com/BariatricSurgery/Forms.aspx

Select Medical Weight Loss-New Patient Packet #1

Medical Weight Loss Programs

St. Elizabeth PHYSICIANS

Weight Management Center
4900 Houston Rd.
Florence, KY 41042
Phone: (859) 212-4625
Fax: (859) 212-4638

Required Labs:

- ☐ **CBC w/diff**
- ☐ **CMP**
- ☐ **TSH**
- ☐ **Free T3**
- ☐ **Free T4**
- ☐ **Lipid Panel**
- ☐ **HgA1C**
- ☐ **Fasting Insulin**
- ☐ **Uric Acid**
- ☐ **Magnesium**
- ☐ **Vitamin D 25OH**

☐ **EKG (for VLCD program)**
(this can be performed in house unless patient chooses to have done elsewhere).

*****NEW PATIENT PACKET MUST BE COMPLETED ENTIRELY PRIOR TO ARRIVAL FOR INITIAL BARIATRICIAN VISIT. YOU WILL BE ASKED TO RESCHEDULE IF THIS IS NOT COMPLETED AND AVAILABLE WHEN YOU ARRIVE.**

PLEASE ARRIVE 45 MINUTES BEFORE YOUR APPOINTMENT TIME FOR YOUR FIRST VISIT WITH DR. SCHUMANN OR DR. CATANZARO TO ALLOW CLINICAL STAFF TIME TO ENTER YOUR INFORMATION INTO THE ELECTRONIC MEDICAL RECORDS****