Concept Chiropractic
+ Regenerative Medicine
Renew Yourself

WEIGHT LOSS PATIENT REGISTRATION

PATIENT INFORMATION

Patient First Name:	Patient Middle Name:	Patient Last Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	☐ I authorize Concept Chiropractic and Regenerative Medicine to leave a message on all answering services.
Birth Date:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		Gender: ☐ Male ☐ Female
Email:	☐ I authorize Concept Chiropractic and Regenerative Medicine to send me emails for reminders, e-statements/bills, and informational newsletters.		
Occupation:	Employer's Name:		
Employer's Street Address:	City:	State:	Zip:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Relationship:	Phone Number:
☐ I authorize Concept Chiropractic and Regenerative Medicine to leave or give information to spouse, emergency contact or any member of household.		

REFERRAL SOURCE AND PRIMARY CARE DOCTOR INFORMATION

How did you hear about us?	Primary Care Physician:

If you would like to put a credit card on file check the box and fill in your Credit Card Information

☐ I prefer to be charged automatically on my credit card for any out of pocket cost or balances relating to my care and treatment that are not covered By my insurance. With the signature at the bottom of the page I authorize Concept Chiropractic and Regenerative Medicine to charge any of these charges on the credit card listed below. I will present the card at the first visit. To protect my safety the complete credit card number cannot be kept on file:

☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER Last 4 Digits of CC#: _____ Exp Date: _____

By signing the bottom of this page I authorize that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filing fees for withholding information as it relates to my medical history and insurance coverage.

_____ _____ _____

Print Name Signature (Parent/Guardian if patient is a minor) Date

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FINANCIAL POLICY

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered a CASH patient for all weight loss services including initial consultation, lab work, and weekly injections.
3. In the event I discontinue my plan of care prior to the doctor's consent, I am responsible for any outstanding balance.
4. I agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.
5. I agree that in order for Concept Chiropractic and Regenerative Medicine to service my account or to collect any amounts I may owe, Concept Chiropractic and Regenerative Medicine may contact me by telephone at any telephone number associated with my account. This includes wireless telephone numbers, which could result in charges to me. Concept Chiropractic and Regenerative Medicine may also contact me by sending text messages or e-mails, using any e-mail address I have provided to them. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Concept Chiropractic and Regenerative Medicine or any agency working on behalf of Concept Chiropractic and Regenerative Medicine may contact me/us as described above.
6. I understand that I will be charged a $125.00 NO SHOW fee for any missed appointments not canceled with a 24 hour notice. ALL cancellations MUST be made by calling our office at 703.573.5500 at least 24 hours in advance. Attempts to cancel any appointments via email, text message, or any form of social media will not be considered.

By Signing below I agree to all statements in the Financial Policy, Insurance Assignment and Insurance Authorization and Release above.

Print Name	Signature (Parent/Guardian if patient is a minor)	Date

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MEDICAL WEIGHT LOSS INTAKE FORM

CURRENT MEDICAL HISTORY

How did you hear about us? _____

What are your main weight issues and goals?

Are you currently on any weight loss programs or special diet? ☐ Yes ☐ No If yes, please explain.

Do you smoke? ☐ Yes ☐ No If Yes, how many per day: _____

Do you consume alcohol? ☐ Yes ☐ No If yes, what is your weekly consumption? _____

Do you take any medication, birth control, vitamins, mineral or herbal supplements? ☐ Yes ☐ No
If yes, please list all medications:

Personal or family history of thyroid disease or thyroid cancer? ☐ Yes ☐ No

Any history of diabetes and what current medications for diabetes? ☐ Yes ☐ No

_____

a. If diabetic, any history of diabetic retinopathy? ☐ Yes ☐ No

Currently taking any prescriptions with other semaglutide-containing products or any other GLP-1 receptor agonist(s)?
☐ Yes ☐ No

Are you actively enrolled in a weight loss program that involves a reduced calorie diet and increased physical activity adjunct to therapy? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, please specify.

Do you have any type of injury or have you had any type of operation in the last 12 months? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any Allergies? ☐ Yes ☐ No If Yes, please list all allergies and/or reactions to drugs, food, latex, etc.:

FEMALE PATIENTS

Do you have any Allergies? ☐ Pregnant ☐ Trying to get Pregnant ☐ Breast Feeding ☐ Post Menopausal

Have you had a Hysterectomy? ☐ Yes ☐ No If yes, please put date and explain reason:

_____

Number of Pregnancies: _____ Live Births: _____ Date of Last Menstrual Cycle: _____

MALE PATIENTS

Have you had a Vasectomy? ☐ Yes ☐ No If yes, please list date: _____

Are you currently trying to Conceive? ☐ Yes ☐ No

Please list all Surgeries and other Hospitalizations:

Reason: _____ Year: _____ Hospital: _____

Reason: _____ Year: _____ Hospital: _____

Reason: _____ Year: _____ Hospital: _____

PAST MEDICAL HISTORY

☐ Alcohol Abuse	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorder
☐ Bloody Stool	☐ Bronchitis	☐ Cancer	☐ Chest Pain	☐ Constipation
☐ Convulsions	☐ Depression	☐ Diabetes	☐ Diarrhea	☐ Dizzy Spells
☐ Drug Abuse	☐ Eating Disorder	☐ Epilepsy	☐ Fainting Spells	☐ Fatigue
☐ Food Allergies	☐ Frequent Urination	☐ Glaucoma	☐ Gout	☐ Gallbladder Disorder
☐ Headaches	☐ Heart Disease	☐ High Cholesterol	☐ Hypertension	☐ Insomnia
☐ Irregular Pulse	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Mental Illness
☐ Migraines	☐ Moodiness	☐ Palpitations	☐ Pancreatitis	☐ Rashes
☐ Shortness of Breath	☐ Sleep Apnea	☐ Stroke	☐ Thyroid Disease	☐ Ulcers

WEIGHT LOSS AND DIET INFORMATION

Are you currently under the care of a Physician? ☐ Yes ☐ No If yes, please list name of Dr. and Contact Info:

_____

Have you ever had weight loss surgery? ☐ Yes ☐ No Lowest Post Surgery Weight: _____

What do you feel are the main contributors to having excess weight? (Check all that apply):

☐ Child Birth	☐ Family History	☐ Alcohol Intake	☐ Busy Lifestyle	☐ Emotional Eater
☐ Sleep Issues	☐ Hormone Changes	☐ Medical Condition	☐ Sedentary Lifestyle	☐ Menopause
☐ Stress	☐ Excessive Snacking	☐ Late Night Eater	☐ Other:	

What foods do you crave most often and how often do you eat these foods?

What methods have you used in the past for weight loss?

☐ Exercise ☐ Diet Modifications ☐ Prescription Medications ☐ Weight Loss Pills ☐ Therapy ☐ Injections

Please list details of items marked above:

Do you experience any potential weight loss obstacles below?

☐ Skipping Meals ☐ Binge Eating ☐ Stress Eating ☐ Psychological Factors ☐ Unsupportive Partner ☐ None

Please specify if you marked any of the above items:

How long has your weight been an issue? _____

What is your ideal weight? _____ What is your heaviest weight? _____

Are you currently at your heaviest weight? ☐ Yes ☐ No If yes, for how long? _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the practitioner or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures, I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Name	Patient Signature	Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us compliance@chiroregenmed.com. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes; Sale of your information; Most sharing of psychotherapy notes

In the case of fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

Treat you - We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues - We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medication; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

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NOTICE OF PRIVACY PRACTICES

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
View online at www.chiroregenmed.com

NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS AND RESPONSIBILITIES

PLEASE CHECK THE BOX, SIGN, AND DATE below to acknowledge receipt of the HIPAA Privacy Practices and Patient Rights and Responsibilities:

☐ I have read and/or was offered a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities by Concept Chiropractic and Regenerative Medicine.

Print Name	Signature (Parent/Guardian if patient is a minor)	Date

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PATIENT RIGHTS AND RESPONSIBILITIES

YOU THE PATIENT HAVE THE RIGHT TO:

- Be treated with dignity and respect
- Confidentiality
- Participate in the assessment and care planning process
- Be provided service in a timely manner
- Be notified in advance of types of treatment and frequency of treatment being provided
- Be notified of any changes in your plan of care and treatment
- Receive an explanation of the billing process and an explanation of charges
- Express grievance without fear of reprisal or discrimination
- Refuse or discontinue

YOU THE PATIENT ARE RESPONSIBLE FOR:

- Providing information when services are rendered
- Notifying practice when you will not be available for treatment or will be late for treatment
- Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- Notifying the practice of any incident involving the staff or equipment
- Payment of all co-payment or deductible applicable per the insurance plan of your choice

PATIENT EMPOWERMENT CHECKLIST!

1. **COMMUNICATION** - If your condition worsens, please contact us immediately. We are required to give you the dr's cell phone number, their email or both.
2. **FOLLOW UP** - Follow up with all of your doctor's self-care advice, such as:
   - Performing all of your home exercise instructions. If you have any problems doing your home exercises, inform Dr. Hegazi immediately.
   - Follow up with your icing instructions.
   - Watch your ergonomics. Take time to evaluate your work station and how you perform your home related activities and ensure you are always in the "good posture position."
3. **UNDERSTANDING** - Ensure you understand all of your available treatment options, both inside and outside of this office, which Dr. Hegazi has discussed with you.