Application for Weight Loss Program

Patient Information

Date: _____

Name: _____ I prefer to be called: _____

"X" Appropriate Boxes: Male Female Minor Single Married Widowed Separated Divorced

Address: _____

City: _____ State: _____ ZIP: _____ Phone: (____)

Work: (____)_____ Cell: (____)___

The best time to contact me is: _____ A.M. P.M. On my Home Phone Work Cell

Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____

If student, Name of School: _____ City/State: _____ FT PT

Spouse/Parent's Name: _____ Employer: _____

Whom may we thank for referring you? _____

If you were not referred, how did you hear about us? _____

Person to contact in case of emergency: _____Phone: (____)_____

Name of local primary physician: _____ May we contact them?: _____

Email Address: _____ May we contact you via email? Yes No

**We will not sell or distribute your email address to any 3rd parties. Email address is used for newsletter and patient communication regarding special events and announcements.

Responsible Party (Other than self)

Name: _____ Relationship to Patient: _____

Address:_____

City: _____ State: _____ ZIP: _____

Phone: (____)_____ Work: (____)_____ SS#: _____-_____-_____

Health History

☐ Acid Reflux ☐ Allergies ☐ Anemia ☐ Anorexia ☐ Arthritis ☐ Asthma ☐ Bladder ☐ Bowel ☐ Bulimia

☐ Cancer ☐ Chronic Infections ☐ Concussion ☐ Depression ☐ Diabetes ☐ Difficulty Sleeping ☐ Digestion

☐ Dizziness ☐ Elbow/Wrist Pain ☐ Fatigue/Tiredness ☐ Headaches ☐ Heart Disease ☐ Hepatitis ☐ Hernia

☐ High Blood Pressure ☐ High Cholesterol ☐ Immune ☐ Kidney Disease ☐ Knee Pain ☐ Leg/Hip Pain

☐ Liver/Gallbladder ☐ Low Back Pain ☐ Neck Pain ☐ Numb/Tingling (Legs/Feet) ☐ Numb/Tingling (Arms/Hands)

☐ Shoulder/Arm Pain ☐ Sinus ☐ Skin ☐ Stroke ☐ Thyroid ☐ Vision ☐ Weight Problems

www.bpc4u.com

Weight Loss Questionnaire

1. Is there a reason you are seeking treatment at this time?

   _____

2. What are your goals about weight control and management?

   _____

   _____

3. Your level of interest in losing weight is:

   1 2 3 4 5

   Not interested Very Interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

   1 2 3 4 5

   Not Ready Very Ready

5. How much support can your family provide?

   1 2 3 4 5

   No Support Much Support

6. How much support can your friends provide?

   1 2 3 4 5

   No Support Much Support

7. What is the hardest part about managing your weight?

   _____

8. What do you believe will be the most helpful in helping you to lose weight?

   _____

9. What has been your lowest and highest body weight as an adult?

   Lowest: _____ Highest: _____

10. At what age did you start trying to lose weight? _____

11. Please check all previous programs that you have tried in order to lose weight. Indicate dates and length of participation.

Program	**Date**	**Duration (Months)**	**Weight Lost**
Weight Watchers			
Overeaters Anonymous			
Liquid Diets			
Diet Pills (Meridia, Xenical)			
Diet Pills (Phen-Fen, Redux)			
Nutrisystem/Jenny Craig			
OTC Diet Pills			
Registered Dietician			
Obesity Surgery			

12. Have you maintained any weight loss for up to 1 year at any of these programs? ☐ Yes ☐ No

13. What did you learn from these programs regarding your weight?

_____

14. What did not work about these programs?

_____

15. How important is it that you lose weight at this time?
    a. Not
    b. Not Very
    c. Somewhat
    d. Very Important
    e. Imperative

16. Have you tried to lose weight before? ☐ Yes ☐ No

17. What factors led to your success?
    a. Encouragement from others
    b. Determination
    c. Goal – Event with old friends, etc.

18. How does being overweight affect you?
    a. Limits exercise
    b. Can't wear my clothes
    c. Tired all the time
    d. My knees hurt
    e. My back hurts
    f. I feel ugly

19. What has made weight loss difficult?
    a. Travel
    b. Holidays
    c. Weekends
    d. Parties
    e. Hunger
    f. Cost of Care
    g. Peer Pressure
    h. Family

20. What is hard about managing your weight?
    a. No will power
    b. I've always been overweight
    c. No exercise
    d. Schedule too busy
    e. Hungry all the time
    f. I don't like vegetables
    g. I'm a meat and potatoes person
    h. I'm addicted to sugar
    i. I like beer

21. Do you follow a special diet?
    a. No
    b. Diabetic
    c. Low Sodium
    d. Low Fat
    e. Kosher
    f. Vegetarian
    g. Other: _____

22. Which meals do you eat regularly?
    a. Breakfast
    b. Brunch
    c. Lunch
    d. Dinner

23. When do you snack?
    a. Morning
    b. Afternoon
    c. Evening
    d. Late Night
    e. Throughout the day

24. What are your favorite snack foods?

    _____

    _____

25. Do you eat out or order food in? ☐ Yes ☐ No

26. How is your food usually prepared?
    a. Baked
    b. Boiled
    c. Broiled
    d. Fried
    e. Poached
    f. Steamed
    g. Other: _____

27. How many times per day do you have the following items?

Item	Times Per Day
Starch (bread, cereal, pasta, rice, noodles, potatoes)	
Fruit	
Vegetables	
Dairy (milk, yogurt, cheese)	
Meat (fish, poultry, eggs)	
Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)	
Sweets (candy, cake, regular soda, juice)	

28. What beverages do you drink daily and how much?

Drink	Times or 8 oz. glasses per day
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other:	

29. Would you like to change your eating habits? ☐ Yes ☐ No

30. What habits would you like to begin to change?

_____

_____

31. Is your decision to lose weight your own or for someone else?
    a. Mine
    b. My wife
    c. My husband
    d. My parents
    e. My friends

32. Is your family supportive? ☐ Yes ☐ No

33. What can't you do now that you would like to do if you weighed less?
    a. Ride a bike
    b. Go bowling
    c. Play golf
    d. Go for walks
    e. Play with my children/grandchildren
    f. Get into my old clothes

34. What would you like to get out of this visit regarding your weight?
    a. A diet
    b. Accountability
    c. Understanding about what makes me fat
    d. Medication
    e. Evaluation of what is making me fat

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PRIVACY PLEDGE

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not see or provide any of your health information to any outside marketing organization.

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information.

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may disclose your examination, treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
3. Your chiropractor and member of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact our to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b) (1) (iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to your or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances.

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you as a result of a Workers' Compensation injury.
3. If you are/were a member of the armed forces, as we are required by military command authorities to release your health information.
4. If we provide health care services to you as an inmate.
5. If we provide health care services to you in an emergency or disaster relief situation.
6. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide are *Other than the circumstances described in the above examples, any other use or disclosure of your health information will be made with you written authorization.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508 (b) (5) (i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

The Back Pain Center
8821 UNIVERSITY EAST DRIVE SUITE 100
CHARLOTTE, N.C. 28213

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services we provide at a place other than your home, of if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

YOUR RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information in writing.

YOUR RIGHT TO AMEND YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years form the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

YOUR RIGHT TO RECEIVE AN ACCOUNTING OF THE DISCLOSURES WE HAVE MADE OF YOUR RECORDS

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

*Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
*Those disclosures made to you.
*Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
*Those disclosures for national security or intelligence purposes.
*Those disclosures made to correctional officers or law enforcement officers.
*Those disclosures that were made prior to the effective date of the HIPPA Privacy Law.

OUR DUTIES

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health care information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of your health information in our files.

RE-DISCLOSURE

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal law.

TO CONTACT US:

If you would like further information about our privacy policies and practices, please contact: **The Back Pain Center 8821 UNIVERSITY EAST DRIVE SUITE 100 CHARLOTTE, N.C. 28213**

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our practice's Privacy Officer: Dr. NEIL PAI 704-599-0900

If you believe your privacy rights have been violated, you can either file a complaint with this office or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice of the OCR. The address for the OCR regional office for North Carolina is as follows:

Office for Civil Rights U.S. Department of Health and Human Services Atlanta Federal Center, Suite 3870 61 Forsyth Street, W. W. Atlanta, Georgia 30303-8909

ASSIGNMENT OF BENEFITS: I hereby direct _____Insurance Company (or attorney at law) to pay Dr. NEIL PAI directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance payment for professional services. If my current insurance policy prohibits direct payment to DR. NEIL PAI, I instruct you to make out the check to me and mail it as follows: 8821 UNIVERSITY EAST DRIVE SUITE 100. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case. I authorize DR. NEIL PAI to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

CONSENT TO TREAT: I voluntarily authorize DR. NEIL PAI and whomever he designates as assistant or associates to administer examination and chiropractic care as deemed necessary for my condition.

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy of this authorization at my request. This notice is effective as of October 30, 2007. This authorization will expire seven years after the date on which you last received services from us.

_____ _____

Patient Printed Name Patient Signature

_____ _____

Date Witness Signature

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by Neil Pai, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Pai Clinic of Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information if provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during

the course of the procedure which the doctor feels at the time, based upon the facts then know to him or her, is in my best interest.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name Printed Patient Signature

_____ _____

Date Parent/Guardian's Signature

Patient Accepted: YES NO Doctor's Signature_____