Palmetto Primary Healthcare PLLC

New Clinical Weight Management

Patient Packet

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PALMETTO PRIMARY HEALTHCARE, PLLC
MEDICAL WEIGHT MANAGEMENT PROGRAM

WELCOME & PROGRAM OVERVIEW

- Kindly sign all designated areas and initial every page.

Welcome to the Medical Weight Management Program at Palmetto Primary Healthcare, PLLC.

Our program is designed to provide evaluation, education, lifestyle counseling, and when medically appropriate, prescription medication management related specifically to obesity and weight management.

This program is intended to help support healthy and sustainable weight reduction through individualized care plans that may include:

- Nutrition counseling
- Exercise recommendations
- Behavioral and lifestyle modification
- Weight-management medication therapy
- Monitoring of treatment response and side effects
- Laboratory monitoring when clinically indicated

IMPORTANT PROGRAM INFORMATION

Limited Scope of Care

This program is limited to weight management services only.

Enrollment in this program DOES NOT establish a primary care provider relationship for:

- routine preventive care
- management of chronic medical conditions unrelated to weight management
- urgent care
- emergency care
- disability evaluations
- chronic pain management
- specialist management

Patients are responsible for maintaining an established relationship with a primary care provider (PCP) for:

- annual wellness examinations
- preventive screenings
- management of chronic medical conditions
- specialist referrals
- non-weight-related medical concerns

Initial:_____

Emergency Medical Care

This program does not provide emergency services.
If you experience symptoms such as:

- chest pain
- shortness of breath
- stroke symptoms
- severe abdominal pain
- suicidal thoughts
- severe allergic reactions
- loss of consciousness

Call 911 or seek immediate emergency medical attention.

Medication Information

Weight loss medications may not be appropriate for all patients and may carry risks, side effects, contraindications, or interactions with other medications or medical conditions.

Medication availability, insurance coverage, manufacturer shortages, prior authorization requirements, and pharmacy dispensing issues are outside the control of Palmetto Primary Healthcare, PLLC.

No Guarantee of Results

Individual weight loss results vary. No guarantee is made regarding the amount or rate of weight loss.

Patient Responsibilities

Patients participating in the program are expected to:

- provide accurate medical information
- attend scheduled follow-up appointments
- complete recommended laboratory testing
- report medication side effects promptly
- follow medication instructions carefully
- maintain communication regarding changes in health status

We are committed to providing compassionate, evidence-based care to support your health and wellness goals.

Thank you for trusting Palmetto Primary Healthcare, PLLC.

Initial:_____

PATIENT INFORMATION

First, Last Name: _____

Date of Birth: _____

Sex Assigned at Birth: _____

Gender Identity/ Preferred Pronouns (Optional): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Preferred Method of Contact:
☐ Phone
☐ Text
☐ Email

Emergency Contact Name: _____

Relationship to Patient: _____

Emergency Contact Phone Number: _____

Primary Care Provider Information

Do you currently have a Primary Care Provider?
☐ Yes
☐ No

If yes:

Provider Name: _____

Clinic Name: _____

Phone Number: _____

Date Last Seen: _____

Initial:_____

Pharmacy Information

Preferred Pharmacy Name: _____

Pharmacy Address/location: _____

HEALTH HISTORY & MEDICATION FORM

Patient Name: _____

Date of Birth: _____

Current Height: _____

Current Weight: _____

Weight Goal: _____

Medical History

Please check all that apply:

☐ Obesity
☐ Prediabetes
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Disease
☐ Stroke/TIA
☐ Thyroid Disease

☐ Sleep Apnea
☐ Asthma/COPD
☐ GERD/Reflux
☐ Fatty Liver Disease
☐ Kidney Disease
☐ Gallbladder Disease
☐ Pancreatitis
☐ Seizure Disorder
☐ Anxiety

☐ Depression
☐ Bipolar Disorder
☐ Eating Disorder
☐ Substance Abuse History
☐ Glaucoma
☐ Migraines
☐ PCOS
☐ Infertility
☐ Pregnancy
☐ Breastfeeding

Other Medical Conditions:

Surgical History

Current Medications

(Include prescriptions, over-the-counter medications, vitamins, supplements, injections)

Medication	Dose	Frequency

Allergies

☐ No Known Drug Allergies

Please list medication or food allergies and reactions:

Family History

Please check any family history of:
☐ Obesity
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Thyroid Disease
☐ Medullary Thyroid Cancer
☐ MEN2 Syndrome

Initial:_____

Other:

Patient Signature: _____

Date: _____

LIFESTYLE & WEIGHT HISTORY QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Weight History

At what age did weight become a concern?

Highest Adult Weight: _____

Lowest Adult Weight: _____

Have you previously attempted weight loss?
☐ Yes
☐ No

If yes, what methods have you tried?
☐ Diet Programs
☐ Exercise Programs
☐ Prescription Medications
☐ Weight Loss Surgery
☐ Fasting
☐ Commercial Programs
☐ GLP-1 Medications

Other:

Nutrition & Eating Habits

How would you describe your diet?
☐ Excellent
☐ Good
☐ Fair
☐ Poor

How many meals per day do you typically eat?

Do you frequently:
☐ Skip meals
☐ Eat late at night
☐ Eat emotionally/stress eat
☐ Binge eat
☐ Drink sugary beverages
☐ Eat fast food frequently

Exercise

Do you exercise regularly?
☐ Yes
☐ No

Type of Exercise:

Days per week: _____

Minutes per session: _____

Sleep

Average hours of sleep nightly:

Do you snore loudly or have sleep apnea?
☐ Yes
☐ No

Initial:_____

Tobacco / Alcohol / Substance Use

Tobacco Use:
☐ Never
☐ Former
☐ Current

Alcohol Use:
☐ Never
☐ Occasional
☐ Regular

Recreational Drug Use:
☐ Never
☐ Former
☐ Current

Women Only

Are you pregnant or trying to become pregnant?
☐ Yes
☐ No

Are you currently breastfeeding?
☐ Yes
☐ No

Patient Signature: _____

Date: _____

CASH PAY FINANCIAL POLICY

Palmetto Primary Healthcare, PLLC Medical Weight Management Program is a cash-pay service.

Payment Policy

Payment is due at the time of service unless prior arrangements have been made.

Accepted payment methods include:

Initial:_____

- Cash
- Credit Card
- Debit Card
- HSA/FSA cards (if applicable)

Insurance Information

This program is not billed to insurance unless otherwise specifically stated by the practice.

Patients are financially responsible for:

- office visits
- laboratory testing
- medications
- supplies
- pharmacy charges
- outside referrals
- diagnostic testing

Insurance coverage for weight loss medications varies widely and is not guaranteed.

Palmetto Primary Healthcare, PLLC does not guarantee:

- medication approval
- insurance reimbursement
- prior authorization approval
- medication availability

Missed Appointment Policy

A minimum of 24 hours notice is required for appointment cancellation or rescheduling.

Failure to provide adequate notice or failure to attend scheduled appointments may result in a missed appointment fee.

Medication Refill Policy

Medication refills may require:

- follow-up appointments
- updated vitals
- laboratory monitoring
- provider evaluation

Refills are not guaranteed without appropriate follow-up.

Initial:_____

Program Dismissal

Patients may be dismissed from the program for:

- unsafe medication use
- repeated missed appointments
- abusive behavior toward staff
- falsification of medical information
- noncompliance with monitoring requirements
- obtaining weight loss medications from multiple providers without disclosure

I acknowledge that I have read and understand the Medical Weight Management Program Financial Policy.

Patient Signature: _____

Date: _____

INFORMED CONSENT FOR WEIGHT MANAGEMENT TREATMENT

Patient Name: _____

Date of Birth: _____

I voluntarily consent to participate in the Medical Weight Management Program at Palmetto Primary Healthcare, PLLC.

I understand that obesity is a complex medical condition and that treatment may include:

- dietary counseling
- exercise recommendations
- behavioral modification
- laboratory testing
- prescription medications
- ongoing monitoring

Initial:_____

Medication Risks

I understand that weight loss medications may have side effects, risks, contraindications, or interactions.

Potential side effects may include but are not limited to:

- nausea
- vomiting
- diarrhea
- constipation
- abdominal pain
- dehydration
- GERD
- headache
- hair loss
- dizziness
- changes in efficacy of other medications
- elevated heart rate
- elevated blood pressure
- mood changes
- muscle loss
- changes in physical appearance
- allergic reactions
- thyroid complications (including specific cancers)
- decreased vision
- blindness

Some medications may carry additional risks depending on my personal medical history.

Pregnancy Warning

I understand that many weight loss medications are NOT safe during pregnancy or breastfeeding.

I agree to notify the practice immediately if:

- I become pregnant
- suspect pregnancy
- begin attempting conception
- begin breastfeeding

Initial:_____

Follow-Up & Monitoring

I understand that ongoing follow-up appointments and laboratory monitoring may be required for safe treatment.

Failure to follow monitoring recommendations may result in discontinuation of medication therapy.

No Guarantee of Results

I understand that:

- individual results vary
- weight loss cannot be guaranteed
- maintenance of weight loss requires long-term lifestyle modification

Limited Scope of Care

I understand this program is limited to weight management services only and does not replace primary care services.

I acknowledge that I am responsible for maintaining care with my primary care provider and specialists as appropriate.

I have had the opportunity to ask questions regarding treatment, risks, benefits, and alternatives.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Palmetto Primary Healthcare, PLLC

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Palmetto Primary Healthcare, PLLC. **avaiable at www.palmettohealthnc.com**

I understand that this notice describes:

- how my medical information may be used and disclosed

Initial:_____

- my rights regarding my protected health information
- how to access my medical records
- how to request restrictions or corrections

Patient Name: _____

Patient Signature: _____

Date: _____

STIMULANT / CONTROLLED WEIGHT LOSS MEDICATION AGREEMENT

Patient Name: _____

Date of Birth: _____

I understand that medications such as phentermine are controlled substances and may carry risks including:

- elevated blood pressure
- increased heart rate
- insomnia
- anxiety
- dependence
- cardiovascular complications

I agree:

- to take medication only as prescribed
- not to share or sell medication
- not to obtain similar medications from other providers without disclosure
- to attend required follow-up visits
- to report side effects promptly

I understand that:

- lost or stolen prescriptions may not be replaced
- early refills are not guaranteed
- medication may be discontinued if deemed unsafe

I authorize review of the North Carolina Prescription Drug Monitoring Program (PDMP) when clinically appropriate.

Women of childbearing potential agree to notify the office immediately if pregnancy occurs or is suspected.

Initial:_____

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Palmetto Primary Healthcare, PLLC
Medical Weight Management Program

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, or been offered a copy of the Notice of Privacy Practices for Palmetto Primary Healthcare, PLLC.

I understand that the Notice of Privacy Practices describes:

- how my medical information may be used and disclosed
- my rights regarding my protected health information
- how to access my medical records
- how to request restrictions or corrections to my health information

I understand that Palmetto Primary Healthcare, PLLC reserves the right to modify its Notice of Privacy Practices in accordance with applicable law.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

If signed by personal representative:

Representative Name: _____

Relationship to Patient: _____

Date: _____

Office Use Only:

Initial:_____

☐ Patient declined acknowledgment
☐ Unable to obtain acknowledgment

Reason: _____

Staff Initials: _____ Date: _____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH OTHERS

Palmetto Primary Healthcare, PLLC
Medical Weight Management Program

Authorization to Discuss Protected Health Information

I authorize Palmetto Primary Healthcare, PLLC to discuss my medical information, including appointments, laboratory results, medications, billing information, and treatment plans with the individual(s) listed below.

I understand:

- this authorization is voluntary
- I may revoke this authorization in writing at any time
- information will only be disclosed to the individuals listed below unless otherwise required or permitted by law

Authorized Individuals

Person #1

Name: _____

Relationship to Patient: _____

Phone Number: _____

Person #2

Name: _____

Relationship to Patient: _____

Phone Number: _____

Initial:_____

☐ I DO NOT authorize disclosure of my medical information to anyone other than myself.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

CONSENT FOR ELECTRONIC / DIGITAL COMMUNICATION

Palmetto Primary Healthcare, PLLC
Medical Weight Management Program

Consent for Communication by Text, Email, Phone, and Patient Portal

Palmetto Primary Healthcare, PLLC may communicate with patients regarding:

- appointment reminders
- follow-up instructions
- medication information
- laboratory reminders
- billing notifications
- general healthcare communication

These communications may occur by:

- phone call
- voicemail
- text message
- email
- patient portal

Standard message and data rates from your wireless carrier may apply.

Electronic communication may not always be fully secure despite reasonable safeguards. Patients should avoid using electronic communication for urgent or emergency medical concerns.

Patient Communication Preferences

Text Messaging

☐ YES, I consent to receive text messages.

Initial:_____

Phone Number: _____

☐ NO, I do not consent to text messaging.

Email Communication

☐ YES, I consent to receive email communication.

Email Address: _____

☐ NO, I do not consent to email communication.

Voicemail Communication

☐ YES, I consent to voicemail messages.

Phone Number: _____

☐ NO, I do not consent to voicemail messages.

Patient Portal Communication

☐ YES, I consent to patient portal communication.

☐ NO, I do not consent to patient portal communication.

I understand:

- I may revoke or modify this consent in writing at any time
- electronic communication should not be used for emergencies
- I should call 911 or seek emergency medical care for urgent medical issues

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Initial:_____

Consent for video or other recording for security and/or Health Care Operations

To ensure patient safety and the safety of our staff, Palmetto Primary Healthcare, PLLC maintains a highly secured facility. Security cameras are place throughout the facility where legally permissible. By entering the facility, I consent to video, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's healthcare operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to any copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that any recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

I have read and understand the **Security recording** policy above and consent to the conditions stated:

Patient's Signature: _____
or Responsible Party Signature _____
Printed Patient Name: _____

Date: _____

Consent to retrieve prescription history.

Prior to prescribing controlled substances, Palmetto Primary Healtcare, PLLC will review a patient's medication history using the Prescription Drug Monitoring Program of North Carolina and neighboring states. Additionally, medication history may be obtained from current or previous providers to ensure the most comprehensive medication use.

By signing below, I give consent to retrieve prescription history, if available, when request is triggered during scheduling an appointment or ordering a medication, and reconciliation of current medications in my electronic health record (EHR)

Patient's Signature: _____
or Responsible Party Signature _____

Printed Patient Name: _____

Date: _____

GENERAL PATIENT CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a health care provider or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I, the patient, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature: _____
Printed Patient Name: _____
Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____

Office Use Only:
Recorded
by:_____Date:_____