Hoosier Health Plus

Rita Raih, PA-C

Welcome to our practice. I'm honored to be working with you, and I'm committed to providing you with the best care I can. My hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. I will share my medical expertise with you, and I hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well being. Few of us, myself included, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

It will give me great pleasure to work with you on your weight control goals, either through my own expertise, through reading I might give you, or by referring you to the nutritionist at Hoosier Health Plus. I encourage you to keep in contact with your primary care doctor.

We want everyone to be involved in their own health maintenance program. Everyone who joins our practice will start by having a physical exam followed by periodic check-ups to watch out for problems and modify your program. We will make you aware of the food and supplement programs available to *achieve maximum success. Additional tests may be recommended and also medications to assist you will be discussed if you so desire.*

We look forward to working with you. Let's work together to help you live the satisfying life that you deserve.

Enclosed you will find a Patient Registration, Medical History and Screening Forms. Bring all completed forms, driver licenses, bottles of all pills you take including over the counter medications, copies of blood work, EKG (heart test), insurance card and a 3 day food diary, to your appointment ***on*** *_____ @_____* ***.*** *Your cost for your 1st initial office visit could be_____ and any additional medications or supplements****.*** *Because you may be getting an EKG Please wear* ***NO LOTION*** *on the body.* ***We ask everybody to be courteous to all patients/staff and refrain from wearing any perfumes/cologne to your appointment.***

Sincerely,

Rita Raih PA-C and staff

Location:

Hoosier Health Plus
520 East 8th St., Anderson, IN 46012
765-641-7700
www.hoosierhealthplus.com

Hoosier Health Plus
Patient Registration

Date: _____ *SS #*_____/_____/_____ *DL #*_____*State*____ *Exp*___/___

Patient's Name: _____ *Gender: Male----Female* *Age:* _____
Address: _____ Marital Status: S M Sep Div Wid
City: _____ Date of Birth: _____
State: _____Zip: _____ Height: _____Present Weight_____
Home Phone(___)_____ Weight at age 18_____
What Phone number may we leave a DETAILED message on?_____
Pager: _____ Cell Phone: (____)_____
E-Mail Address: _____

Patient's Employment: _____
Address: _____Phone#: (____)_____
City: _____State_____Zip: _____

Spouse, Partner, or Guardian's Information:
Name: _____ *Date of Birth:*_____
SS#:_____ Employment:_____
Emp Phone#:_____ Address:_____
Pager # :_____ Cell Phone #:_____

Family Doctor: _____ Address: _____
Phone:_____City:_____State_____

*Insurance Co:*_____*Give Card to front Desk/Driver License*
*Insurance Cardholder Name:*_____*Employment of Cardholder*_____
*Date of Birth of Cardholder*_____*Relationship to Cardholder*_____
****

Emergency Numbers:
Name:_____ Phone #:_____
(Nearest relative not living with you….Mother..Sister..Aunt..Neighbor..Friend)
How did you hear about our practice: Newspaper---Phone Book---Friend---Physician Referral
Name of Referral: _____

1. All new patients who haven't had a CBC,TSH, Lipid Panel, Complete Metabolic Profile, UA and EKG done in the past 12 months may need those tests done. According to American Society of Obesity Physicians Practice

2. Guidelines, all necessary tests and paper work must be completed and presented before the Physician can place the patient on a VLCD or medication.
3. We accept Cash, Visa, Master Card, Discover, American Express and Debit Cards.
4. To avoid a $25.00 failure charge, notify our office within 24 hours to cancel your appointment.
5. **Prescriptions will not be called into the pharmacy between office visits.** To prevent medication error or substitutes, the Doctor does not refill medications by fax or pharmacy phone calls. Refills must be requested during your visits. If you have a medication from your primary doctor call their office.
6. All programs and Products are nonrefundable.
7. After reviewing your test results and medical history, we cannot guarantee that the physician will prescribe a medication or place you on the program you have requested.
8. We are not Medicare/Medicaid providers for Weight Loss. I understand that Medicare/Medicaid will not pay for any services rendered by Hoosier Health Plus even if I bill Medicare or Medicaid myself. _____initials
9. If Patient is requesting a copy of MD notes, there is a $ .15 charge per page or $ 15.00 for chart.
10. There is a $ 50.00 charge for letters written to summarize physician supervised treatment for purposes of bariatric surgical referral or authorization.
11. We no longer call in medications to pharmacies and/or to mail away pharmacies between office visits. Refill must be requested during your visits. Bring all medications bottles to appointment.

HIPPA:

I consent to Hoosier Health Plus and their physicians to use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and their general operation activities, I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have the right to review and request a copy of the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I give Hoosier Health Plus permission to call my home, work, cell or mail any information regarding my appointment or reminders to me or give any information to my immediate family.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent. I further acknowledge that I have received, reviewed, understood and agreed to the Notice of Privacy Practices of Hoosier Health Plus, which described the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____ _____

Date Signature (Parent or guardian must sign for patients under 18 years old) Witness

Medical History Form

PLEASE FILL IN ALL BLANKS/CIRCLE OR PRINT "NONE" IF APPLICABLE.

Date:_____

Name: _____ Age:_____ Date of Birth_____Sex: M F

Primary Care Physician: _____ Dr. Phone: _____Height_____

Is it OK to send information to your physician YES or NO

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____
3. Are you taking any medications/supplements(over the counter pills) at the present time? Yes No

Med. Name	MG	Dosage	Time Taken	Date Started Med.	For what Problems?
	/	/	/	/	
	/	/	/	/	
	/	/	/	/	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. Any allergies or sensitive (side effects) to any medications? Yes No
   Medications: _____/_____ Type of Reaction:_____/_____
   _____/_____/_____ _____/_____/_____
5. Have you ever had a history of High Blood Pressure? When:_____ Yes No
6. Have you ever been told you have High Blood Sugars (Diabetes)? When:_____ Yes No
7. Have you ever had heart problems, Heart attack or Chest Pain? Yes No If yes when_____Where_____
8. Have you ever had a stress test on your heart? Yes No If yes when_____Where_____
9. History of Swelling Feet Yes No If Yes when_____
10. History of Headaches? Yes No How Often:_____ Medications_____
11. Have you ever had Migraines? Yes No Medications for Migraines: _____
12. History of Constipation (difficulty in bowel movements)? Yes No How often do you have bowel movements_____
13. Last Eye Exam?_____ Have you ever had glaucoma? Yes No

14. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____ Any High Blood Sugars? Yes No

    What are you using to prevent pregnancy?_____

15. Other Medical Problems_____ Yes No
    _____

14. Any Hospitalizations Yes No
    Specify: _____ Date: _____
    Specify: _____ Date: _____

15..Any Surgery: Yes No
    Specify: _____ Date: _____
    Specify: _____ Date: _____

16. History of sleep problems? Yes No Have you had a sleep study? Yes No What was the result?_____

Reviewed by Physician_____(initials)

NAME:_____DOB:_____TODAY'S DATE:_____

PLEASE FILL IN ALL BLANKS/CIRCLE OR PRINT "NONE" IF APPLICABLE.

Your Past Medical History: (check all that apply) write down date of illness

_____ High Blood Sugars	_____ Jaundice	_____Chest Pain	_____ Arthritis
_____ Kidney Disease	_____ Scarlet/Rheumatic Fever	_____ Liver Disease	_____ Lung Disease
_____ Chicken Pox	_____ Bleeding Disorder	_____ Gout	_____ Osteoporosis
_____ Ulcers	_____ Thyroid Disease	_____ Anemia	_____ Heart Valve Disorder
_____ Heart Disease	_____ Tuberculosis	_____ Gallbladder Disorder	_____ Blood Transfusion
_____ Drug/Alcohol	_____ Eating Disorder(anorexia)	_____High Chol.	_____ Depression
_____ Pneumonia/Asthma	_____ Marijuana Treatment	_____ Cancer	

_____Chronic pain What hurts_____Circle level 1 2 3 4 5 6 7 8 9 severe

Family History:

At what age did any of your family members have the following:

	Alive	Death	Stroke	Heart	Thyroid	Diabetes	Glaucoma	Obesity	B/P	High Chol.	Other	No Problems
Age of Father:												
Age of Mother:												
Age of Brothers												
Age of Sisters:												

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight_____
2. In what time frame would you like to be at your desired weight? _____Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____
6. What has been your maximum lifetime weight (non-pregnant) and when?_____
7. Previous diets you have followed: When/How much did weight did you lose? What Medications used Any Side Effects?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

8. Who lives in your Home? _____ ages _____

_____ ages _____

9. How often do you eat out? _____ Where?___ When_____
10. Who plans meals? _____ Cooks? _____ Shops? _____
11. Do you use a shopping list? Yes No
12. Food allergies: _____
13. Food dislikes: _____
14. Food you crave: _____ When? _____
15. Do you drink coffee or tea? Yes No How much daily? _____
16. Do you drink soft drinks? Yes No How much daily? _____diet or regular
17. Do you drink alcohol? Yes No What Kind ?_____How many a week?_____
18. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____ Olive Oil? _____
19. Do you awaken hungry during the night? Yes No

What do you do? _____

20. What are your worst food habits? _____
21. Snack Habits: What? _____ How much? _____ When? _____
22. When you are under a stressful situation at work or family related do you tend to eat more? Explain:

_____

_____

23. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

Reviewed by Physician_____(initials)

NAME:_____DOB:_____TODAY'S DATE:_____

PLEASE FILL IN ALL BLANKS/CIRCLE OR PRINT "NONE" IF APPLICABLE.

26. Are you being physically abused Yes No Sexually abused Yes No Emotionally abused Yes No

27. In the past have you been Physically abused Yes No Sexually abused Yes No Emotionally abused Yes No

28. 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 used to smoke _____ packs per day_____for years_____but Quit_____year
_____ You smoke _____Cigarettes per day For _____ years?

29. Have you ever taken Wellbutrin or Zyban? Yes No Why?_____

30. Describe your usual energy level: _____

31. 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.

32. Behavior style: **(answer only one)**
_____ You are always calm and easygoing.
_____ You are sometimes calm with frequent impatience.
____ You are seldom calm and persistently driving for advance
_____ You are never calm and have overwhelming ambition.

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

34. Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

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.

Reviewed by Physician_____(initials)

Weight Loss Program Consent Form

I _____ authorize Hoosier Health Plus and whomever is designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for duration's exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(Or person with authority to consent for patient)

12 Reasons
"Why I want to Reach My Goal Weight"

Name_____Date_____

It is important that these 12 reasons be true personal goals and desires. **They should not be generalizations or what you think would please others because they will be used as your "personal motivator."** Try to make them specific, measurable, and time related. (EX. I want to be able to walk 5 blocks without being short of breath by June 2013)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

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