Weight Loss Clinic Patient Information Sheet

Name:_____ **Date of Birth**:_____

Address:_____ **Marital Status**: S M W D

_____ **Sex**: M or F

Home Phone #:_____ **Cell Phone #**:_____

☐ Ok to leave a message at either of the above numbers **S.S. #**:_____

Email Address:_____

Employer:_____ **Work Phone #**:_____

Employer Address: _____

☐ Ok to leave a message at work

Primary Care Physician:_____

Primary Care Physician Contact #:_____

Emergency Contact Information

Name:_____ **Primary Phone #**:_____

Address:_____ **Alternate Phone #** _____

_____ **Relationship To Patient**:_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have reviewed the contents of the Patient consent and Disclosure of Protected Health Information and understand the terms enclosed in the document

Financial Policy

Thank you for selecting ***Family Medicine Associates of Lincoln County, PLLC*** for your weight loss needs. We are honored to be of service to you. This is to inform you of our financial policy. Please be advised that payment will be due in full at the time services are rendered. For your convenience we accept Debit cards, MasterCard, Visa, Discover, Flex spending cards and cash. No personal checks will be accepted as payment, nor will we file weight loss services to your health insurance.

I accept full responsibility for all charges related to the Weight Loss Program.

Patient Signature: _____

Date: _____