The Center For Weight Management – Since 1989

PERSONAL INFORMATION

NAME: ______________________________ TODAY'S DATE: ________________

SOCIAL SECURITY NUMBER: ____________________ BIRTH DATE: ____________________

ADDRESS (No P.O. Box):____

CITY/STATE: ______________________________ ZIP: ____________________

TELEPHONE - HOME: ______________ WORK: ______________CELL: ______________

EMAIL:______________________________ OCCUPATION: ____________________

PRIMARY CARE PHYSICIAN: ____________________ MEDICAL INSURANCE: ____________

HOW DID YOU HEAR ABOUT US? (Circle all that Apply):

Television, News, Yellow Pages, Internet, Our Sign, American Society of Bariatric Physicians (ASBP)

Patient: ____________________Doctor: ____________________ Other: ______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME: ____________________________RELATIONSHIP: ____________________________

TELEPHONE - HOME: ______________WORK: ______________ CELL: ______________

PLEASE LIST ALL PERSONS, RELATIONSHIP, AND PHONE NUMBER YOU AUTHORIZE *The Center for Weight Management* TO RELEASE HEALTH-RELATED RECORDS; TREATMENT, FINANCIAL DOCUMENTS AND APPOINTMENT INFORMATION, TO WHEN NECESSARY.

1) ____

2) ____

3) ____

4) ____

PLEASE READ AND SIGN BELOW IF YOU UNDERSTAND AND AGREE WITH THE FOLLOWING STATEMENT:

Ed J.Hendricks, MD is not a Medicare "Provider," nor is he a "Provider" for any health insurance program. Neither Medicare nor MediCal will cover for weight control services. Medicare will not accept charges for weight loss under any circumstance, although Medicare will pay for Bariatric surgery. We do not bill other insurance carriers for services or products, but will provide patients with information to submit to insurance companies for reimbursement in the event patient's insurance carrier will cover some of our services and products.

We may dispense certain medications in the course of your treatment. If you prefer to obtain these medications elsewhere, we will be happy to write prescriptions for any medication we dispense in-house.

I acknowledge that I am financially responsible for charges incurred at each appointment and for payment at time of service.

I understand that fees may apply if I do not give at least 24 hours notice when rescheduling or canceling an appointment.

By providing my email address above, I give permission to be added to the email list for email updates and specials. I may be removed from the list at any time by sending a request to be removed to info@hendricksforhealth.com.

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SIGNED: ____ DATE: ________________________________

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