Physician's Choice Wellness, LLC

Phone: 217-864-2085

WWW.HealthyLifestyleWeightLoss.com

Please complete the attached &
bring this paperwork to your appointment.

If you are entering any of our medically monitored programs - YOU WILL NEED TO BE **FASTING 12HRS** PRIOR TO THIS APPOINTMENT IF WE ARE DRAWING YOUR LABS FOR YOUR SCREENING INTO OUR PROGRAM. You ARE allowed to have water **(please come hydrated)** and coffee if the coffee is black with nothing added.

If you have BCBS, Aetna, Coventry or Medicare/Medicare Supplement Insurance, please bring your insurance card to this appointment. You will be expected to pay for all non-billable charges + any CoPays and/or Coinsurance amounts that your insurance carrier will not cover at the time of service.

Please feel free to call us if you have any questions or need to reschedule this appointment.

Thank you,

Your PCW Team

217-864-2085

ILLINOIS LOCATIONS

Effingham
1105 W St. Anthony Ave
Effingham, IL 62401
Ph: 217-855-8808
Fax: 217-864-2324

Forsyth
849 Rt 51 South
Forsyth, IL 62535
Ph: 217-864-2085
Fax: 217-864-2324

Mt. Zion
1045 N State Hwy 121
Mt. Zion, IL 62549
Ph: 217-864-2085
Fax: 217-864-2324

Taylorville
1000 Spresser
Taylorville, IL 62568
Ph: 217-864-2085
Fax: 217-864-2324

Vandalia
Fayette County Hospital
650 W Taylor St,
Vandalia, IL 62471
Ph: 217-855-8808
Fax: 217-864-2324

Attendance Policy

- Clients are required to attend a weekly clinic/class session during the Reducing, Adapting, and Sustaining phases of the program.
- Clients are expected to arrive on time for their scheduled clinic/class session (Within the first 30 min. of the clinic/class time).
- Clients arriving more than fifteen (15) minutes after the scheduled start time may be asked to schedule a make-up session with a counselor for an additional fee.
- During the Reducing and Adapting phases, clients will be allowed to miss no more than three (3) consecutive sessions. These absences include excused as well as unexcused absences. Clients missing more than three (3) sessions may require a "Restart" of the program to ensure success. Close medical supervision and accountability is essential.
- When alternate arrangements need to be made due to schedule conflicts, the Physician's Choice Wellness team must be notified at least 24 hours in advance. In an emergency situation, the center must be notified prior to the scheduled start of clinic/class session. In any case, the client is required to attend another session that week in the following week.
- Clients should notify the team at least two (2) weeks prior to vacation so that arrangements can be made for additional products and appropriate counseling.
- During the sustaining phase, the clinic fee will continue to be collected for the six (6) weeks of the sustaining phase.
- With sufficient attendance during the sustaining phase, & by maintaining a goal weight within 5-10lb of that goal weight, lifelong beverage purchasing privileges are obtained.
- In the event a private consultation with a counselor is scheduled, there will be an additional fee for this service.

I, the undersigned, fully understand and agree to the terms and conditions of the Physician's Choice Wellness Attendance Policy.

_____ _____

Client's Signature Date Staff Signature Date

Client Commitment Form

Commitment

Realizing that losing weight will require a great deal of time and effort on my part, I _____ wish to participate in the Physician's Choice Wellness Weight Management Program.

I must meet medical and psychological screening criteria established by the team of weight loss management professionals before entering the program. If medical complications unrelated to weight lose arise during the program, I will be referred back to my primary care physician.

If it is determined that I need additional counseling regarding an eating disorder I may be referred to a PCW counselors or outside counselor, who specialize in this type of counseling.

My goal is to lose weight and keep it off! I agree to participate in and complete all phases of the program—Reducing, Adapting, and Sustaining.

I will attend weekly sessions during all phases of the program and will notify the staff in advance when I am unable to attend. I realize that there is an attendance policy, and I commit to following this policy. I also realize that I have the option of leaving the program at any time but I must notify the center one week before I depart.

I understand that in the interest of my health I must maintain my weight loss once I reach my healthy goal weight. Therefore, I am making the commitment to understand and practice the lifestyle changes presented in this program. If I find myself having difficulty, I will not hesitate to contact a member of the team for assistance.

Involvement/Product

I agree to adhere to the Physician's Choice Wellness program by being actively involved in the weekly sessions. I also agree to purchase and consume the amount of NEW DIRECTION Nutritional Products prescribed to me. I understand that the beverage is my sole source of nutrition. Once I have purchased the beverage it is not returnable. I realize that if I am not complying with the program, I can be discharged.

I understand the program offers the following services to make my weight loss effective and safe:

- Medical and psychological screening before entering the program
- Routine visits with the program physician or physician extender
- Weekly sessions that include information on behavior modification, nutrition education, and exercise
- NEW DIRECTION Nutritional Products
- Individual consultation about program-related issues that may be initiated by the team or by me
- Biweekly/Monthly lab tests (in some programs)
- EKG monitoring at regular weight loss intervals (50lb or more of weight loss)

I have read all the above statements and understand their meaning. It is my wish to participate in the NEW DIRECTION System as designed by Physician's Choice Wellness under the conditions described.

_____ _____

Client's Signature Date Staff Signature Date

Rev 11/17

Physician's Choice Wellness, LLC

Physician's Choice Wellness Financial Policy

I, _____ understand and agree that health and accident
PRINT NAME OF PATIENT
policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I discontinue utilizing the Physician's Choice Wellness program, any fees for professional services rendered me will be immediately due and payable. I understand that I have the option of making a payment arrangement with Physician's Choice Wellness if necessary but should my account become more than 60 days past due, with no payment being made, my account will be turned over to a collection agency and /or attorney to collect any unpaid balance at that time. I further understand that if my account is turned over to a collections agency and / or attorney due to non-payment, then I agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to; total remaining balance, a collection agency fee of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

I understand that the time of each PCW team member is very valuable. Therefore, if I do not cancel or reschedule any appointment with a PCW team member within 24 hours of the appointment, I will be charged $25.00.

Further billing and financial policies and practices:

- We will never charge a debit/ credit card without consent. Consent is given by listing “cc” on your encounter form for listed charges or by returning the bottom portion of a billing statement with “charge cc” listed.
- HSA/Benny/FSA may not cover product. We are not responsible for refunding any charges you choose to place on your HSA/FSA/Benny card that deny.
- If you plan to pay all of your billable charges with an HSA/FSA/Benny card, we will not charge anything to this card up front (even a copay) if you have BCBS. Instead we will send a statement once insurance process the claim.
- A balance that is carried on 3+ billing statements may result in removal from our program. Statements are sent monthly. All questions regarding billing should be handled in our billing department. 217-864-2085 Opt 1.
- Only one credit / debit card may be put on file. Upon receipt of a billing statement the patient will have the opportunity to complete the bottom portion of the statement listing the information for any card not placed on file (i.e.: Benny cards, FSA cards, etc.)
- PCW reserves the right to charge patients $1 finance charge on all statements carrying a balance for over 30 days.

_____ _____

Patient Signature Date

A. Physician's Choice Wellness
1045 N State Hwy 121
Mt. Zion, IL 62549

Medicare Participants Only

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical CPT 99385-99387	Not a covered expense	$180-$225
Physical CPT 99395-99397	Not a covered expense	$160-$185
Diabetes Management	Non-Billable Service	$45
Clinic Visit CPT 99211	Patient's Deductible may not be met	$20
Recheck CPT 99212-99214	Patient's Deductible may not be met	$45-$85
EKG w/ Reading CPT 93000	Non-Billable Service	$75
Nutritional Consult	Non-Billable Service	$25-$75
Behavioral Consult	Non-Billable Service	$25-$75
Body Comp Testing	Non-Billable Service	$25-$50
Nutritional Supplements	Non-Billable Product	$8-$25/Unit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Protected Health Information Access Form
Family, Friends and Others
Involved in your care

Physician's Choice Wellness, LLC prides itself for the close relationships we have with our patients. But we may not be sure, in every case, whether a family member or friend is involved in your care. We ask that you complete this form to inform us of those individuals. We will enter this information in our computer systems to assist our staff in verifying a person's involvement. By identifying your caregivers, you can avoid problems that may arise when our staff does not know a person's relationship to you and your care, including those involved in the payment of your health care services, such as guarantors.

Patient Name _____ Date of Birth _____

Patient Address _____
(Street) (City) (State) (Zip)

By completing this form and signing below, you are granting Physician's Choice Wellness, LLC permission to share protected health information (PHI), including without limitation, appointment information, test results, diagnosis, treatment plans, or payments on services, with the individual(s) listed below who is/are a family member, close friend, or other person involved in your care. Under certain medical circumstances, however, a licensed health care professional may identify on or more individuals after determining in his/her professional judgment that sharing PHI on a continual bases would be in your best interest (e.g. emergency situations, patient has Alzheimer's and no power of attorney was granted to the caregiver, etc.) There may be other medical situations where we may disclose PHI to family members or friends in accordance with federal or state law. Categories of people will not be accepted (e.g. "all family members" or "all member of your church") because of the difficulty in verifying their identity.

Name	Relationship	Address and Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature (required): _____ Date: _____

Staff Signature (if applicable): _____ Date: _____

Physician's Choice Wellness, LLC

Name: _____

Date: ____ / ____ / ____

DOB: ____ / ____ / ____

Initial Screening Physical Questionnaire

Primary Care Provider: _____(____)_____

Name Address Phone

Medications

Please list ALL medications including prescription and OTC medications. (You may attach a list)

Drug	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List any Allergies: _____

DO YOU HAVE (Please circle all that apply)

Hypertension/High BP Yes No
Heart Disease Yes No
Gout or hyperuricemia Yes No
Degenerative arthritis Yes No
Any kind of arthritis Yes No
If yes, what kind? _____
Diabetes Mellitus Yes No
High Cholesterol of triglyceride Yes No
Liver Disease Yes No
If yes, do you have a special diet? Yes No
Kidney Disease Yes No
If yes, do you have a special diet? Yes No
Stomach Ulcers Yes No
Inflammatory bowel disease Yes No

HAVE YOU HAD (Please Circle all that apply)

Heart Attack Yes No
If yes, when? _____
Cancer Yes No
If yes, what kind and when? _____
When was last treatment? _____
Cortisone/prednisone Yes No
If yes, when? _____
Bone fracture in past 3 months Yes No
If yes, what bone? _____

PLEASE LIST ALL SURGERIES:

_____
_____
_____
_____

Signature: _____ Date: _____ / _____ / _____

Physician's Choice Wellness, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Physician's Choice Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by Physician's Choice Wellness describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at Physician's Choice Wellness.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Physician's Choice Wellness reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to Physician's Choice Wellness.

With this consent, Physician's Choice Wellness may call/text my home/cell or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, such as appointment reminders, calls pertaining to clinical care, including lab test results, among others.

With this consent, Physician's Choice Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient correspondence.

With this consent, Physician's Choice Wellness may email to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, such as appointment reminders and patient correspondence. I have the right to request that Physician's Choice Wellness restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Physician's Choice Wellness to use and disclose my PHI to carry out treatment, payment and health care operations.

I may revoke my consent in writing except to the extent that the practice already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Physician's Choice Wellness may decline to provide treatment to me.

_____

Name (Print)

_____ _____

Signature Date

Rev 11/17

Enrollment Application

For The New Direction VLCD and New Direction LCD

CONFIDENTIAL

Email:_____ Date:_____

NOTE: This form must be completed before you can be enrolled in the New Direction ND System. Please answer every question. Please print, type or write clearly.

Name (First, Last, Initial)		
Address (Street-City-State-Zip)		
Occupation	Name of Employer	Daytime Phone No.
Birth Date (Month-Day-Year)	Circle Marital Status Single Married Divorced Separated Widowed	Evening Phone.
Circle Level of Highest Education Completed Grade School High School Some College College Grad Grad School Some Tech School Tech School Grade		Gender (Circle) Male Female

Race (Circle one) **American Indian or Alaska Native** **Asian** **Black or African American** **White (Caucasian)** **Native Hawaiian or Pacific Islander**
Other **Decline to Answer**

Smoking Status (circle one) **Never Smoked** **Occasional smoker** **Every day smoker** **Former smoker/yr quit_____**

Ethnicity (Circle one)
Hispanic or Latino **Non Hispanic or Latino** **Decline to Answer**

Preferred Language
English **Spanish** **Other**

Please give the name and address of a friend or relative with a stable address (for emergency)

Name (Last-First-Initial)	Address (Street-City-State-Zip)	Phone No.

Have you been treated at this health care facility before? Yes No

WEIGHT HISTORY

Patient Weight (lbs)	Indicate ages during which you were overweight	
Present Height (feet-inches)	Childhood (Age 2-11 yrs)	Age 20-29 yrs
What is your goal weight?	Adolescence (Age 12-19 yrs)	Age 30-40 yrs
When did you last weigh this amount?		Over 40 yrs

How much weight do you expect to lose during this program?_____ lbs

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. Nutrisystem, Jenny Craig, Starvation, Weight Watchers, Protein Formula, Psychotherapy, Medications, Spa Hypnosis, Etc.)

Weight Loss Method	How long was loss Maintained?	Why did you stop treatment?	Issues during treatment?	Which weight loss method was most successful?
Sample: Stillman Diet	2 years	Desired other foods	Dizziness	
				What accounted for that success?

PSYCHOSOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (eg. marriage-divorce-job change-death of someone important to you)? If so, describe

What other commitments do you think might interfere with you fully participating in the New Direction System?

What benefits do you hope to gain from being in this program **other than losing weight**?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle your choices)

Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel will **NOT** be supportive of your weight loss and changes in lifestyle? (circle your choices)

Spouse Children Roommates(s) Parent(s) Friend(s) Co-worker(s) Other

List five reasons you thinks it is important for you to lose weight

1.

2.

3.

4.

5.

Why did you choose this particular program?

LIFESTYLE AND EATING HABITS

Do you drink alcohol? Yes No

If yes, how often?

- ☐ Less than 1 drink a month
- ☐ 1 drink a month
- ☐ 1 drink a week
- ☐ More than 1 drink a week
- ☐ 1 drink a day
- ☐ More than 1 drink a day

How often do you exercise?

- ☐ Rarely
- ☐ Occasionally
- ☐ 1-2 times a week
- ☐ 3-4 times a week
- ☐ 5 or more times a week
- ☐ What type of exercise?

Has any doctor or other health care professional ever told you not to exercise? ☐ Yes ☐ No

Do you know of any reason why you should not exercise? ☐ Yes ☐ No

If you answered yes to either question, please explain

_____

_____

How many meals do you typically eat out per week? _____

Are the majority of these meals with family or friends? Yes No

Are the majority of these meals alone? Yes No

Majority of meals eaten out? ____ Breakfast Lunch Dinner

Are they usually fast food? Yes No

Are they usually cafeteria/restaurant? Yes No

Of the following, check all the items that you feel help explain or describe your eating habits:

- ☐ Thinking about food too much of the time
- ☐ Eating high-fat foods
- ☐ Eating too many sweet foods
- ☐ Eating too quickly
- ☐ Uncontrollable binges
- ☐ Eating in reaction to tension and depression
- ☐ Overeating when alone
- ☐ Using food as a reward
- ☐ Eating to take my mind off other problems
- ☐ Not paying attention to what I'm eating
- ☐ Overeating at social events
- ☐ Lack of satisfaction in life
- ☐ Eating in reaction of boredom
- ☐ Other (explain)

Are you allergic to:

Cocoa	☐ Yes	☐ No
Milk Protein	☐ Yes	☐ No
Corn	☐ Yes	☐ No
Soy	☐ Yes	☐ No
Eggs	☐ Yes	☐ No

Other foods _____

Are you sensitive to or do you have a problem with:

Aspartame (NutraSweet)	☐ Yes	☐ No
Monosodium glutamate (MSG)	☐ Yes	☐ No
Lactose (unable to drink milk but able to eat cheese and yogurt)	☐ Yes	☐ No

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SMS Consent

I _____ agree to receive text messages.
PRINTED Legal Name

to this mobile phone number (___) ___-____ as long as I am enrolled in the Physician's Choice Wellness Program, reminding me about my upcoming appointments. I understand that SMS reminders are optional and that message & data rates may apply.

If you would prefer to use email, please write your address below.

_____

Email address

_____ ____ / ____ /____

Signature Date

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Vandalia
Fayette County Hospital
650 W Taylor St,
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Physician's Choice Wellness, LLC

Treatment Consent Form

AUTHORIZATION FOR EXAMINATION AND TREATMENT

1. I have had explained to me the risks and benefits of the Physician's Choice Wellness Weight Management Program. I understand it is a medically monitored program for rapid, safe weight loss and complete education to help with weight maintenance. I knowingly and voluntarily desire to participate in the program.
2. I am aware that I must meet medical and psychological screening criteria established by the Physician's Choice Wellness team of weight management professionals before entering the program.
3. I hereby authorize and consent to have Physician's Choice Wellness physicians perform complete physical, and diagnostic procedures including blood tests, electrocardiogram ("EKG"), and possibly a stress test and/or chest radiography for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.
4. As part of the Physician's Choice Wellness program continuous medical monitoring is mandatory. Consequently, upon acceptance to the program, I willingly agree to have this monitoring performed (blood tests, periodic EKG, and other tests as indicated).
5. I am aware that during the fasting period possible side effects may occur from ketosis. These side effects have been explained to me, and I have had opportunity to ask any questions regarding these effects.
6. I have been informed that any weight loss regimen increases the chance of gallstone formation.
7. If medical complications unrelated to weight loss arise during the program, I am fully aware I will be referred back to my primary care physician for treatment and evaluation.
8. I recognize that if I should become pregnant my participation in the Physician's Choice Wellness program must be terminated.
9. I understand that I will pay for my Products and program services on a weekly basis. I understand that it is my responsibility to pay for these services myself, but that proper information will be provided so that I may file the billable charges with my medical insurance. I understand I am fully responsible for payment of the entire charges AT THE TIME they are received regardless of whether I have or believe I have insurance coverage, which would apply.
10. No guarantee has been given to me by anyone as to the results that may be obtained.
11. Having been advised of the above, I authorize and consent to the performance of the procedures and other treatment of the program.
12. ☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature of frequent visits of a weight loss program and may be copied upon request.)

Physician monitoring is required to help minimize the potential for health risks. VLCD participants will be seen MONTHLY, during the entire reducing phase. It is my (participant's) responsibility to make sure these appointments are scheduled and attended on a regular and routine basis.

_____ _____

Participant Date PCW Team Member Date