Kimberly A. Johnston, M.D.

Patient Information Form (please print)

Patient Name_____Date_____
Street Adresss_____Home Phone_____
City_____State_____Zip_____Work Phone_____
Have You Ever seen Dr. Johnston Before?_____Referred _____
Social Security #_____Marital Status_____Date of Birth_____
Patient Employer Name_____Occupation_____
Address_____Phone Number_____
Spouse or Parent/Guardian Information
Name_____Social Security#_____
Address_____
Employer Name_____Phone Number_____
Address_____

Please be advised that the center for medical weight loss does not submit medical insurance claims. Weight loss is generally a non-covered benefit, however if appropriate our staff will be happy to provide all information necessary for individuals to submit for reimbursement independently.

Assignment of Insurance Benefits

Please Read & Sign The Following:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I directly assign all medical benefits to Kimberly Johnston, M.D. and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Johnston to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this original shall be as valid as the original.

SIGN HERE_____DATE_____

Authorization To Release Test Results

I give my consent to the office of Dr. Johnston to release any test results ordered by this office to the following person if I am unavailable.

NAME_____Relationship_____

PHONE_____Address_____

Signature_____Date_____

WEIGHT CONTROL
EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us? (**Please circle all that apply to you)** Newsday, Daily

News, Magazine, Radio, Google, mdbethin.com, liwli.com, Parent, Friend,

Doctor, Drive by or Other ……

How much weight do you expect to lose? ……. Each week? …… Each month? ……

What will happen if you don't lose that much or that fast? How will you react? ……..

……..

If your weight loss slows down markedly or even completely stops for a while, will you

understand the difference between fat loss and water loss? ……

What size clothes do you expect to be able to wear when you reach your goal weight?

…….

What do you expect from us (your medical counselors)? Be specific: ……..

…….

Will it change your life in any way (for better or worse) when you reach your goal

weight? ……

Do you expect to be doing anything you are not doing now? (describe in detail) …….

…….

Do you expect to STOP doing something you ARE DOING NOW? (describe in detail)

……

Will you be able to handle compliments about how you look when you are of normal size? ……

Will your “new” normal weight self” pose a threat to your relationship with “significant others?” (how specifically?) ……

How will family and friends respond to the “new you?”……

Do you expect to get a better job? ……

Will you get more respect from other people?(Who specially)…….

Will you feel comfortable with these altered responses from others? ……..

Will you be expected to perform better at work (or at home)? …….

Will you have to be more sociable than you are now? …….

Will you have to assume any new responsibilities (please describe)? …….

……

What will happen if some of your expectations don’t come true? What might you do?

……

What do you expect to have to do to maintain weight the same? …….

……

Will you continue to watch your food intake? …….Exercise? ……...…....

Continue with professional medical monitoring? …….For about how long?.....

Do you have any other expectations than those listed above?.....Specifically, what are they? Please describe them in detail …….....

……

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Patient Name:_____Date:_____

Email Address: _____

Appointment Cancellation Policy

As a result of not having any available appointments in our schedule and in order to best serve our patients, the following policy is necessary:

There will be a $75 charge if you fail to cancel your scheduled appointment in advance. Your credit card will or you will be billed $75 on the day of your visit if you fail to cancel your appointment prior to the scheduled time.

Payment in full is necessary prior to any treatments being rendered. The payment is non-refundable and non-transferable. In the event that you are unable to complete a pre-paid treatment regimen you could finish the treatment at a later date. (Up to one year from your last appointment)

By signing below I agree that I was informed of this office policy.

X_____

_____
(Patient name)

Date _____/_____/_____