HEALTHY LIVING™
DIABETES & ENDOCRINOLOGY CENTER OF OHIO

Patient: _____

Is scheduled for an appointment with **Jennifer McCann, MS, RDN, LD**
for
☐ DECO Healthy Living Weight Loss Program -*OR*- ☐ Nutrition Counseling

On _____ at _____ AM/PM

- **Please plan to arrive 10 minutes prior to your scheduled appointment time to allow for check in procedures.**
- **If you are unable to arrive by your scheduled appointment time it may be necessary to reschedule your appointment. Please call if you are late or unable to make your scheduled time. Early notice appreciated.**
- **A current insurance card, prescription coverage card (if applicable), photo identification and any copay or coinsurance must be presented at check-in.**

To expedite the check-in process, please complete the attached paperwork prior to your appointment.

Please fax, e-mail, or mail paperwork *at least* 48 hours before appointment

Fax: 614-764-1707
Email: DecoDietitian@gmail.com
Mail: DECO, Inc. 7281 Sawmill Road | Dublin, Ohio 43016

If you have any questions regarding this paperwork or your visit, please contact our office at (614)764-0707
We are here to assist you Mon – Wed 7:30am-3:30pm, Thurs 8:00am-5:00pm, and Fri 7:30am-2:30pm

PLEASE NOTE: Our office is located in an office park at the corner of Sawmill Rd. and Bright Rd/Sawbury Rd. (just north of 270 off Sawmill Rd.) You cannot see our office from Sawmill Rd. We are in an office park with several other one-story buildings. There is a BP gas station across the street from our office park. Our Building is 7281 and there are signs in the windows for DECO, Inc. If you are traveling Northbound on Sawmill Rd and you get to Hard Rd, you've gone one intersection too far. You enter the office park from Bright Rd and when you turn into the office park we are the first building on your left.

****Please be sure to complete all applicable pages in this packet****

NEW PATIENT NUTRITION PAPERWORK DATE_____

Patient Demographics

First Name	Last Name	MI	Date of Birth
Address	**City, State**	**Zip**	**SSN#**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Gender: ☐ Female ☐ Male ☐ Transgender

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline/Refuse to Report

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Hispanic ☐ Other Race ☐ Other Pacific Islander ☐ Decline/Refuse to Report

PLEASE CHECK PRIMARY PHONE

☐ Home Phone	☐ Cell Phone	☐ Work Phone

Ok to leave message? ☐ **Yes** ☐ **No** **If so, what kind?** ☐ **Extended** ☐ **Brief**

Email Address:

Preferred Contact ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Insurance Information

Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		**Claims Mailing Address (Street or Box)**	
City / **State** / **Zip**		**City** / **State** / **Zip**	
Policy ID	**Group ID**	**Policy ID**	**Group ID**
Subscriber Name (Policy Holder)	**DOB**	**Subscriber Name (Policy Holder)**	**DOB**
Subscriber SSN	**Relationship to Patient**	**Subscriber SSN**	**Relationship to Patient**

Emergency Contact

Relationship to Patient:
(ex: husband, wife, daughter)

First Name	Last Name	MI	Date of Birth
Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	

Pharmacy Information	
Mail Order Pharmacy	**Local Pharmacy**
Name:	
Address:	
Medications & Vitamins/Supplements **(including insulin, birth control such as IUDs, etc). Attach additional sheets if needed**	
Medication Name	**Dosage**
Medications Tried and Failed	
Medication Name	**Dosage**
Medication Allergies – List all known allergies and reactions	
Medication Name	**Reaction**

Past / Present Medical History – Check if you have ever experienced the following conditions and year of onset (if known)					
Condition	**Year of Onset**	**Other Medical Conditions**	**Year of Onset**	**Other Medical Conditions**	**Year of Onset**
☐ **Diabetes Mellitus ☐ Type 1 ☐ Type 2)**					
☐**High Cholesterol (Hypercholesterolemia)**					
☐**High blood pressure (Hypertension)**					
☐**Coronary Artery Disease/Stents/Heart Attack**					
☐**Stroke/TIA**					
☐**Kidney disease/dysfunction**					
☐**Depression or Anxiety**					
☐**Cancer:**					
☐**Acid Reflux (GERD)**					
☐**Peripheral Vascular Disease (PAD)**					
☐**Hyperthyroidism**					
☐**Hypothyroidism**					
☐**PCOS**					

List All Hospitalizations		
☐ **I have never been hospitalized**		
Date	Hospital	Reason

List All Surgeries		
☐ **I have never had a surgery**		
Date	Hospital	Reason

NEW PATIENT NUTRITION PAPERWORK DATE_____

Family History-
Check if any family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Cancer-Type	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Health Maintenance –
Check if you have received the following, and date and location of most recent exam

Exam	Date	Doctor/Location of Test
☐Cardiac Stress Test		
☐DEXA Scan/ Bone Density Test		
☐Eye Exam		
☐Foot Exam		
☐Flu Vaccine		
☐Pneumococcal Vaccine		

Social History

How many pregnancies? _____ ☐ N/A	How many Children? _____ ☐ N/A

Tobacco Use ☐No	☐Social ☐Light ☐Heavy ☐Former/Year Quit_____ ☐Chewing ☐Pipe ☐Cigar ☐Cigarette
Alcohol Use ☐No	☐Daily ☐Weekly ☐Less ☐Former/Year Quit_____ ☐Beer ☐Wine ☐Liquor
Exercise Activity ☐None	☐Light ☐Moderate ☐Vigorous Days/Week_____
Special Diet ☐No	☐Diabetic ☐Vegan ☐Gluten Free ☐Low Salt ☐Vegetarian ☐Low Sugar Other:

Please print clearly

Specialty	Name of Physician/Provider	Last Visit	Phone Number	Fax Number
Primary Care				
OB/GYN				
Ophthalmologist				
Podiatrist				
Cardiologist				
Nephrologist				
Other:				

Employment Information			
☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Self-Employed ☐ Active military duty ☐ Veteran ☐ Not Applicable			
Employer Name	Job Title		Work Phone (optional)
Address	City	State	Zip
Student?	Full-time or part-time?	Grad/Undergrad?	School:

NEW PATIENT NUTRITION PAPERWORK DATE_____

Weight and Nutrition History Questionnaire

Have you seen a Registered Dietitian before? ☐ Yes ☐ No **How recently?** _____

What is your reason for seeing DECO's Registered Dietitian? ☐ Weight loss needs ☐ Weight gain needs ☐ Carb counting education ☐ Recent diagnosis and confusion with diet needs/changes (**diagnosis**: _____) ☐ To gain general nutritional health knowledge ☐ Other _____

How did you learn about or were referred to DECO's dietitian? _____

****Please skip any questions that are not relevant to your needs (i.e. if you are not seeing the dietitian for weight loss)****

If applicable, when did you begin or have significant weight gain?

☐ Since Adolescents ☐ After Pregnancy ☐ After Employment Change ☐ During a Stressful Period ☐ After Marriage ☐ Other _____

How many meals do you eat daily? _____ **Do you eat a snack(s) during the day?** ☐ Yes ☐ No ☐ 'Graze' all day long

Have you made attempts to 'diet', follow a meal plan, or partake in a weight loss program? ☐ Yes ☐ No **How many?** _____

What is the longest you have stayed on a personalized diet plan or been with a weight loss program?

☐ 0-2 months ☐ 3-6 months ☐ 7-12 months ☐ Over 12 months

What weight loss or diet change methods have you tried in the last 5 years?

☐ Weight Watchers ☐ Food logging ☐ Weight Loss Medications ☐ Other Diet Centers ☐ Physicians ☐ Do It Yourself ☐ Other _____

If applicable, why have you discontinued the above methods of weight change?

_____

If applicable, which weight loss/ diet change method do/did you consider most successful, and, what accounted for this success?

_____

(If applicable) How important is it to you to lose weight?

☐ Extremely Important ☐ Very Important ☐ Important ☐ Not Very Important ☐ N/A

(If applicable) Why do you want to lose or gain weight?

☐ Promote social activity ☐ Appearance ☐ Special Occasion ☐ Health Reasons ☐ To Please Others ☐ Other _____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with partner **Who does majority of groceries/ cooking?** _____

Has your spouse/partner encouraged you to lose weight? ☐ Yes ☐ No ☐ N/A **Do you feel supported in your goals?** ☐ Yes ☐ No

Number of children (if applicable):_____ **Ages?**_____ **Do they live in your household?** ☐ Yes ☐ No ☐ Part-time

Do You work outside of the home? ☐ Yes ☐ No **Occupation?** _____

Current Height: _____ **Current weight?** _____ **Have you lost or gained any weight in the last year?** ☐ Yes ☐ No

If yes, How much (gain or loss?) _____

Goal weight (not required) _____ **Highest weight in last 5 years?** _____ **Lowest weight in last 5 years?** _____

Do you consume alcohol? ☐ Yes ☐ No **Type consumed?** ☐ Wine ☐ Beer ☐ Liquor **Frequency?** ☐ <1x/month ☐ 2x/month ☐ Weekly ☐ Daily

How often do you exercise? ☐ Rarely ☐ Occasionally ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 or more times per week

Type of exercise you do:_____ **length of time:** _____

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

Do you know any reason why you should not exercise? ☐ Yes ☐ No **If yes why?** _____

Number of meals eaten out per week? _____ **Are these most often sit down, take out, fast food, or a combination?** _____

What meal is normally eaten out? ☐ Breakfast ☐ Lunch ☐ Dinner **Are these meals with family or friends?** ☐ Yes ☐ No ☐ Sometimes

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

☐ Thinking about food too often ☐ Not paying attention to what I'm eating ☐ Eating high-fat / calorie dense foods ☐ Eating too many sweet foods ☐ Eating foods quickly ☐ Uncontrollable binges ☐ Eating in reaction to emotions ☐ Eating to take mind off other problems ☐ Lack of satisfaction in life ☐ Overeating at social events ☐ Eating in reaction to boredom ☐ Overeating when alone ☐ Skipping meals/ going too long between meals & snacks ☐ Using food as a reward ☐ Grazing through the day ☐ Not sure what's a good choice ☐ Other _____

Are you presently going through any major lifestyle change (marriage, divorce, job change, move, illness, death of a loved one?)

_____

List 3 reasons it is important to be at a healthy weight for you.

1) _____
2) _____
3) _____

Please List any current vitamins/minerals, herbs, or supplements not on above medications list (if all are listed skip this question):

_____

_____

Please list any food allergies (i.e., shellfish, dairy, gluten) or *intolerances* (i.e., lactose, sugar alcohols, sugar alternatives, etc.):

_____

Please note *strongly disliked* foods:

_____

Are you currently or regularly experiencing symptoms of: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Reflux

Do you follow a special diet? □ None □ 'Diabetic' □ Low carb □ Gluten Free □ Low Salt □ Vegetarian □ Vegan □Heart healthy □ Other

_____

Do you suffer of have ever suffered from depression, anxiety, insomnia, or disordered sleep patterns? (PLEASE Specify)

_____

Do you or have you ever experienced disordered eating patterns? (i.e. anorexia, binging, and/or purging) □ Yes □ No
If yes to above, is this a current concern? □ Yes □ No
Have you in the past -or- are you currently seeking treatment? □ Yes □ No

Please describe your *typical day's* food & beverage intake:

Meal./drink/ time of day	**"Good day"/ "Healthier day"**	**"Not so good day"/ "Less ideal day"**
Breakfast **Time:**		
Lunch: **Time:**		
Dinner: **Time:**		
Snack(s) **Time(s):**		
Fluid intake **(amount and type)**		

What percent of your week is a "good day"?_____

STOP- If the DECO Healthy Living Weight Loss Program is **not** the reason you are seeing the dietitian today, please skip the following section and move on to the **Financial Policy on page 12**

DECO HEALTHY LIVING QUESTIONNAIRE: please circle/ highlight the answer that best describes how you feel.

Section 1: Goals and Attitudes

Compared to previous attempts, how motivated are you to lose weight this time?

1	2	3	4	5
Not At All Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Consider all outside factors currently in your life (the stress you're feeling at work, your family obligations, etc). To what extent can you tolerate the effort required to stick to a meal plan?

1	2	3	4	5
Cannot Tolerate	Uncertain	Can Tolerate Somewhat	Can Tolerate Well	Can Tolerate Easily

Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 0.5 to 2 pounds per week while on the FULL Healthy Living program, how realistic is this expectation to you?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Unsure (But I'm willing to try!)	Somewhat Realistic	Very Realistic

If going on a meal plan, do you fantasize or get cravings for a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

When starting on a meal plan, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE_____

If you scored:

6 to 16:	This may not be a good time for you to start a weight loss program. Low motivation and commitment together with unrealistic goals could block your progress. Think about and address possible barriers and consider how you may change them before undertaking a formal weight loss program. Consider starting with Nutrition Counseling only.
17 to 23:	You may be close to being ready to begin a program but should think about ways to boost your preparedness before you begin. Try making a list of pros vs. cons for starting a formal weight loss program or list *reasons* to lose weight for YOU. You may also start with Nutrition Counseling as it may be a helpful option for you at this time.
24 to 30:	You may be ready to start our weight loss program after your consultation with our dietitian!

Section 2: Hunger and Eating Cues

When food comes up in conversation, in something you read, or on TV, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

How often do you eat because of physical hunger? (i.e., listening to your personal hunger and fullness cues?)

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Do you have trouble controlling your intake/ portion when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE_____

If you scored:

3 to 6:	You might occasionally eat more than you would like, but it does not appear to be a result of high responsiveness to environmental cues. Controlling the reasons that make you eat may be especially helpful.
7 to 9:	You may have a moderate tendency to eat just because food is available. Having a meal plan may be easier for you if you try to resist external cues and eat only when you are becoming physically hungry.
10 to 15:	Some or most of your eating may be in response to thinking about food or exposing yourself to temptations to eat. Think of ways to minimize your exposure to temptations so that you eat only in response to physical hunger. (And not waiting until you are 'starving' as this can lead to over-indulging as well)

Section 3: Control Overeating

If the following situations occurred while you were following a meal plan, would you be likely to eat more, less, or no different?

Although you packed or had your lunch planned, a friend talks you into going out to lunch.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

You "break" your meal plan by eating a less ideal, "forbidden" food. (***note****: there are no 'forbidden foods' just moderation and healthier choices*)

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

You have been following your meal plan faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE_____

If you scored:

3 to 7:	You recover rapidly from "going off-track". However, if you frequently alternate between eating out of control and dieting strictly, you may have a disordered eating pattern and should seek professional guidance.
8 to 11:	You do not seem to let unplanned eating disrupt your program. This is a flexible, balanced approach.
12 to 15:	You may be prone to overeat after an event breaks your control or throws you off track. Let's focus on your reactions to these problem-causing events or 'barriers to success' as they can be improved.

Section 4: Binge Eating and Purging

Aside from holiday feasts, **have you ever** eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2	0
Yes	No

If you answered yes above, how often have you engaged in this behavior during the last 12 months?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Have you ever purged (used laxatives, diuretics, induced vomiting, or excessive exercise [>2 hours/day]) to control your weight?

2	0
Yes	No

If you answered yes above, how often have you engaged in this behavior during the last 12 months?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Section 4 TOTAL SCORE_____

If you scored:

0 to 1:	It appears that binge eating, and purging, is not a current concern. *(Please discuss this in a judgment-free zone with our program's dietitian if you did not want to record any of the above behaviors on paper*)
2 to 9:	Pay attention to these eating patterns. Should they arise more frequently, please seek professional help. Treatment options can be discussed with your primary care provider, DECO physicians, or our program's dietitian.
10 to 16:	These results show signs of a potentially serious eating disorder or disordered eating pattern. Please discuss with your primary care provider, DECO physicians, or our program's dietitian to find a counselor experienced in this area.

Section 5: Emotional Eating

Do you eat more than you would like to when you experience anxiety, depression, anger, or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Do you have trouble controlling your eating when you have positive feelings - do you celebrate feeling good by eating?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 5 TOTAL SCORE_____

If you scored:

3 to 8:	You do not appear to let your emotions affect your eating.
9 to 11:	You sometimes eat in response to emotional highs and lows. Monitor this behavior to learn when and why it occurs and be prepared to find alternative activities.
12 to 15:	Emotional ups and downs can stimulate your eating. Try to deal with feelings that trigger the eating and find other ways to express them.

Section 6: Exercise Patterns and Attitudes

How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Somewhat	Frequently

How confident are you that you can exercise regularly?

1	2	3	4	5
Not At All Confident	Slightly Confident	Somewhat Confident	Highly Confident	Completely Confident

22. Does the thought of exercise elicit a positive or negative picture in your mind?

1	2	3	4	5
Completely Negative	Somewhat Negative	Neutral	Somewhat Positive	Completely Positive

23. How certain are you that you can work regular exercise into your daily schedule?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCORE_____

If you scored:

4 to 10:	You're probably not exercising as regularly as you should. Determine whether your attitude and feelings about exercise are blocking your way, then change what you must and put on those walking shoes.
11 to 16:	You need to feel more positive about exercise, so you can do it more often. Think of ways increase activity that are fun and fit your lifestyle.
17 to 20:	It looks like you are motivated to get and/or stay active! Plan for barriers that may come up to maintain this focus.

STOP- The page is only for individuals interested in knowing more or starting the DECO Healthy Living Weight Loss Program, if you are not please move on to the **Financial Policy on page 12**

Side Effects Possible from a Modified Very Low-Calorie Diet

People on a very low-calorie diet may experience mild, temporary side effects as their body adjusts to the diet. Notify the dietitian or see your primary care doctor about any symptoms that persist or concern you. Side effects may include:

□ **Dizziness** - As you begin losing weight, you lose a lot of water as urine. This lowers blood volume and, hence blood pressure. To minimize dizziness, avoid changing positions quickly; don't use whirlpools, saunas or steam baths; and drink plenty of water.

□ **Fatigue, Dry Skin, Sensitivity to Cold -** These are generally mild and can be treated with extra rest, lotions/creams and extra clothing.

□ **'Fruity' Breath –** Ketosis is NOT our goal but may occur and temporarily give your breath a fruity odor, if this does occur, we will correct it.

□ **Gallstones -** Tell the dietitian about any symptoms or history of gallstones; you may require additional tests or treatment while on this program.

□ **Gastrointestinal Upset -** Changing from solid foods to a mostly liquid diet may cause constipation/diarrhea. Over the counter medications are available for either condition. In addition, your medical team can add a Fulfill Fiber product to your meal plan to help relieve constipation.

□ **Hair Loss -** A small percentage of patients may experience patchy hair loss 3-6 months into the diet. Frequently, new hair grows as old hair is lost.

□ **Leg Cramps -** Drinking more fluids or increasing electrolytes can often relieve occasional or mild leg cramps. Your physician should evaluate any leg pain you are experiencing.

□ **Menstrual Irregularities -** Dietary changes may cause delayed or missed periods. Women who miss a period or have a late period should be tested for pregnancy.

Patient Commitment

I realize that losing weight will require a great deal of time and effort on my part; I wish to participate in the DECO Healthy Living Program. I understand that this program is medically monitored for weight loss and weight management.

□ I understand that my goal is to lose weight and to keep it off. I agree to participate in all phases of the program – Active Weight Loss, Adapting and Maintenance (S.T.A.R.).

□ I must meet medical and psychological screening requirements established by the DECO Healthy Living team. If medical complications unrelated to weight loss arise during the program, I understand that I will be referred back to my private physician.

□I understand that I must weigh in weekly. If I must miss a week, I will notify the dietitian 1 week before. Emergency situations will be excused.

□ I understand that maintaining weight loss is in the BEST INTEREST OF MY HEALTH and will follow up with maintenance visits as decided on.

□ I will make the commitment to understand and practice the lifestyle changes presented in the DECO Healthy Living Program.

□ If I find myself having difficulty, I will not hesitate to contact the DECO Dietitian (Jennifer) for assistance.

_____ _____

Patient Signature Date

Authorization for Examination and Treatment

Initials	Commitments
	Having been explained the risks and benefits of the DECO Healthy Living Program, a medically monitored program for rapid, safe weight loss and complete education to help manage weight, I knowingly and voluntarily desire to participate in the Program.
	I am aware that I must meet medical and psychological screening requirements established by the DECO Healthy Living Team before entering the Program.
	I hereby authorize and consent to have the DECO Healthy Living Program physicians to order complete physical and diagnostic procedures including blood tests, electrocardiogram (EKG), and possible a stress test and/or chest radiography for evaluation purposes. I have had and will have the opportunity to ask questions regarding the diagnostic procedures and my health.
	As part of the DECO Healthy Living Program, continuous medical monitoring is mandatory. Consequently, upon acceptance into the Program, I willingly agree to have this monitoring performed (blood tests, periodic EKG and other tests as indicated).
	I am aware during the weight loss period possible side effects may occur from a modified very low-calorie intake. Possible ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). If this occurs, I will discuss with the program's dietitian to modify my meal plan. Other side effects include dizziness, fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea, and/or constipation.
	If medical complications unrelated to weight loss arise during the Program, I am fully aware I will be referred to my private physician.
	(if applicable) I recognize that if I should become pregnant my participation in the Program must be terminated.

Financial Policy

Insurance Information

As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note your health insurance is a contract between you and your insurance company so it is your responsibility as the patient to make sure our physicians are covered under your plan. All insurance companies do not carry the same benefits so the services rendered to you in this office may or may not be covered. It is the patients' responsibility to know what is covered and if you need a referral.

1. A valid insurance card must be presented at each visit. If you do not have an insurance card with you and you are unable to obtain a copy prior to your appointment, you will need to pay based on our self-pay fee schedule. Once we have received payment from your insurance company, we will refund any monies due.

2. Co-pays are due at the time of service. If you do not have the co-pay amount, you may be charged a $25 fee. This may be billed to you, along with your co-pay amount, upon receipt of payment from your insurance company. This fee will not apply to lab visits. This fee differs for Nutrition Counseling visits.

3. In order to successfully file a claim with your insurance company, you must provide all the requested information on the patient demographics form. This includes:

- **subscriber's name**
- **subscriber's date of birth**
- **subscriber's social security number**
- **relationship to subscriber**

4. Quest Diagnostics (lab office at DECO) bills for all traditional Medicare, Tricare, Champva, Caresource, Molina, Aetna, UHC, and Anthem insurances. This process is subject to change and without notice.

Dietitian Services

Patients who are participating in the DECO Healthy Living Program will not be charged a co-pay for the visit, fees are included in the pricing of the program at the patient's out of pocket expense and include a $10 service fee for ALL visits (virtual and in-office) and cost of product. We do bill your insurance for the medical monitoring and labs required for the program (if in network). **For patients who wish to see the dietitian for only nutrition counseling services** (including meal planning, carb counting, recipe review, etc.) your insurance will be billed. Most insurance companies will pay for a percentage of nutrition counseling services, but not all, you may be charged after these visits up to a **max** out of pocket rate of $100 depending on time spent in your session (all consults are 1 hour in length). For patients who attend group classes with our Registered Dietitian (held two times per month), your insurance will be billed for the class; however, we will **not** pass along any additional charge to the patient. Patients who no-show their visit with the Dietitian, or have re-occurring late arrivals, will be charged a no-show fee of $10.

Self-Pay Patients

All patients without insurance must pay for the visits at the time of service. Copies of the self-pay rates will be available upon request.

Statements

We will mail statements to the patient approximately every 30 days. A statement will be mailed to the patient once payment or further information regarding the visit has been received from your insurance company.

Payment Arrangements

Under special circumstances payment arrangements can be made with our offsite billing department. They can be contacted at 614-764-0707, select option 2.

Financial Agreement

The responsible party agrees to pay any amount that is allowed but not paid by the insurance company, within 90 days. Failure to keep your account current may result in suspension of treatment or in the termination of the patients' relationship with the practice and providers. Unpaid accounts will be sent to a collection agency and may be assessed a 35% service charge. We accept cash, check, MasterCard®, Visa®, American Express® and Discover®. Checks that are returned as Non-Sufficient Funds will be assessed a $25.00 returned check fee.

I have read and fully understand the above policy.

_____ _____

Patient or authorized Representative Signature Date

Dietitian Services Cancellation and No-Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you **provide more than 24 hours' notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that slot to other patients.

Consistent occurrences of any three of the following: no shows, late arrivals, or same day cancellations may lead to a discharge from the program. **No show appointments or appointments which are cancelled less than 24 hours in advance will be subject to a $10.00 'no-show' fee (this fee is for dietitian services only. No-show and late cancellations fees defer for other appointments with DECO)**. *This will be strictly enforced for any reoccurring no show appointments*.

Patients who do not show up for their appointment without a call to cancel the appointment will be considered as NO SHOW.
The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full by the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with the program director's approval. Our program firmly believes that good staff/patient relationship is based upon understanding and good communication.

Questions about cancellation and no-show fees should be directed to the program director at 614-764-0707.

_____ _____
Patient Signature Date

Consent for Service

Assigned of Insurance Benefits

I hereby authorize direct payments of medical benefits to Diabetes & Endocrinology Center of Ohio, Inc for services rendered by them in person or under their supervision. I understand that by signing this form, I am financially responsible for payment of any balances due.

Failure to complete all information may result in patient being billed directly for services.

Consent to Treatment

I hereby authorize treatment by the providers and staff as they deem medically necessary for conditions diagnosed.

Printed Name:_____ **Date**_____

Patient Signature_____

____☐**Yes**☐**No** I consent for my email provided to be added to the DECO Dietitian's email list so I can receive Monthly Newsletters with FREE group classes and healthy living tips (1-2 emails per month will be sent)

HIPAA Consent

The professionals at Diabetes and Endocrinology Center of Ohio are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

Name: _____ **DOB**: _____

(Please print)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (FILL IN/CIRCLE ALL THAT APPLY)

Primary Phone: _____

Leave a detailed voice mail message? Y N

Leave a message with call back number? Y N

Email Address: _____

Leave a message to call us? Y N

Other request: _____

May we speak to someone else regarding your medical care? Yes / No

Name & phone of person: **Relationship**

_____ _____

_____ _____

I have been made aware of the privacy policies of DECO and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices. I understand I may revoke this consent at any time.

Signed: _____ Date: _____

Witness: _____

Acknowledgement of Privacy and Confidentiality Policy

• If I am not available, I acknowledge that personal and confidential medical information about me, may be left with the person I named above.

• I do so voluntarily and by signing below, I waive this confidentiality.

• It may be left on my answering machine if indicated above.

• I am aware that this permission can be revoked at any time.

Patient Signature: _____ Date: _____

Privacy Notice

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED/ DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION.
This Notice of Privacy Policy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use your protected health information in the following situations without your authorization. These situations include: as required by law public health issues as required by law, communicable diseases, health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners; funeral directors and organ donation, research; criminal activity; military activity and national security, and workers compensation.
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative mean or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us of the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.
This notice was published and became effect on April 14, 2003
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or at our main phone number.
We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. (Health^4). Health^4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health^4.

CDC-Kaiser Adverse Childhood Experience (ACE) Study

Adverse Childhood Experiences - Linking Childhood Trauma to Long-Term Health and Social Consequences
A questionnaire was sent to over 13,000 adults who voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health and over 9,000 responses were received and processed.

Here's What Was Learned
Many people experience harsh events in their childhood. 64% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma or Adverse Childhood Experiences (ACEs). 11% experienced emotional abuse, 28% experienced physical abuse, 21% experienced sexual abuse, 15% experienced emotional neglect, 10% experienced physical neglect, 13% witnessed their mothers being treated violently, 27% grew up with someone in the household using alcohol and/or drugs,19% grew up with a mentally-ill person in the household, 23% lost a parent due to separation or divorce, 5% grew up with a household member in jail or prison.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:
Coronary Artery Disease (CAD), Obesity, COPD, Poor Health-Related Quality of Life, Liver Disease, STD/STIs, Alcoholism/ Alcohol Abuse, Smoking, Depression, Unintended Pregnancies, Fetal Death, Multiple Sexual Partners, Illicit Drug Use, Suicide Attempts

Talk with your primary care doctor about what happened to you when you were a child. Ask for help. For more information about the ACE Study visit the Centers for Disease Control and Prevention at: www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/

Please complete the following questionnaire to learn your ACE score if you are comfortable doing so. We have found this questionnaire beneficial in improving and providing best outcomes in our nutrition counseling and Healthy Living services.

While you were growing up, prior to your 18th birthday:

1) Did a parent or any other adult in the household **often**……
Swear at you, insult you, put you down or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
☐ Yes ☐ No

2) Did a parent or any other adult in the household **often**……
Push, grab, slap or throw something at you?
or
Ever hit you so hard you had marks or were injured?
☐ Yes ☐ No

3) Did an adult or person at least 5 years older than you **ever**……
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
☐ Yes ☐ No

4) Did you **often** feel that……
No one in your family loved you or thought you were important or special?
or
Your family did not look out for each other, feel close to each other, or support each other?
☐ Yes ☐ No

5) Did you **often** feel that……
You did not have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
☐ Yes ☐ No

6) Were your parents **ever** separated or divorced?
☐ Yes ☐ No

7) Was your mother or stepmother (or father or step father)……
Often or very often pushed, grabbed, slapped or had something thrown at her?
or
Sometimes, often or very often kicked, bitten, hit with a fist or hit with something hard?
or
Ever repeatedly hit for at least a few minutes or threatened with a gun or knife?
☐ Yes ☐ No

8) Did you live with anyone who was a problem drinker or alcoholic or anyone who used street drugs?
☐ Yes ☐ No

9) Was a household member depressed or mentally ill, or did a household member attempt suicide?
☐ Yes ☐ No

10) Did a household member go to prison?
☐ Yes ☐ No

Each "Yes" answer is a score of 1

Please add up your "Yes" answers: _____This is your ACE Score

***The ACE score measure 10 types of childhood trauma, each type of trauma counts as one. This is not to discredit other forms of childhood trauma that are experiences- i.e. racism, bullying, death of loved ones- but is used to measure the most common traumas found and researched by Kaiser members. This is meant to be used as a guideline, not a definite risk to your health outcomes; however, a significant link between childhood trauma and chronic disease later in life has been supported. Therefore, the higher your ACE score, a higher risk of social, emotional, and health concerns may be present.**