BioBalance Health Weight Loss Program

Dear Patient,

Thank you for your interest in BioBalance® Health and our medicated weight loss program. Our metabolism slows as we age, primarily because we lose muscle mass and replace it with fat. This process begins when our testosterone begins to drop to a critical level and continues throughout our lives. This makes weight loss more difficult as we age. Unfortunately the loss of muscle and increase in fat causes health problems that worsen over time.

BioBalance Health, LLC offers the most comprehensive fat loss program in St. Louis and Kansas City. We combine individualized weight loss medication that increases metabolism and accelerates loss of weight, diet counseling for your blood type and genetic inheritance, review and planning of your exercise program, and the most effective hormone replacement with bio-identical testosterone pellets that increase muscle mass and decrease body fat. This program is individually designed by reviewing all of the components of your lifestyle.

The goal of our program is to speed up your metabolism, decrease hunger, and shape your body from the inside out to rebuild the body of your youth. Our "secret weapon" for weight loss is our i-Lipo Laser that melts fat away in the most important areas (waistline, back fat, and hips) while you lose total weight w th our prescription medication program. Losing weight looks the best when you can target your fat loss by using our i-Lipo Laser sculpting treatments.

Please complete, sign, and return the attached forms.

BioBalance Health
10800 Olive Blvd. Creve Coeur, MO 63141
Attn: Receptionist
Fax: (314) 218-3999
Email: newpatient@biobalancehealth.com

Once we receive your information we will contact you to schedule your initial consultation. Thank you and we look forward to seeing you soon!

Sincerely,

Kathy C. Maupin, M.D.

Rachel Maupin Sullivan, D.O.

Weight Loss Questionnaire

Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
Email:			SSN:
Address:			City:
State:	Zip:	Age:	Date of Birth:
Referred by:		Primary Care Physician:	
OBGYN or Urologist:		Marital Status:	
Occupation:		Employer:	

Emergency Contact Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Email:	

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Fax: (314) 218-3999

Weight Loss Questionnaire

Medical Information

Blood Type:		
Height:	Weight:	Goal Weight:
What diet programs have your tried?		
Current dress size or pant waist size		
Ideal dress size or pant waist size		
Are you still fertile (Yes/No)?		
Are you a current BioBalance Health pellet patient (Yes/No)?		

Birth Control Method (Check all that apply).

	Menopause
	Hysterectomy
	Tubal ligation
	Birth control pills
	Abstinence
	Same sex partner

	Vasectomy
	Mirena IUD
	Other IUD
	Other:

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Weight Loss Questionnaire

Current Medications (List all current medications)

Drug	Dose	How Often?

Supplements (List all current supplements)

Supplement	Dose	How Often?

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Medical History (Check all that apply)

	Hepatitis or HIV (List Type)
	Breast cancer
	Uterine cancer
	Colon cancer
	Ovarian cancer
	Other cancer
	Blood clot or clotting disorder
	Heart attack
	Stroke
	Vascular disease
	High blood pressure
	High cholesterol
	Heart arrhythmia
	Emphysema (COPD
	TB (Tuberculosis)
	Glaucoma
	Depression/Anxiety
	Manic depression (bipolar) or mania
	Schizophrenia

	Psychological/psychiatric illness
	Sleep apnea
	Narcolepsy
	Arthritis
	Rheumatoid arthritis
	Osteopenia or osteoporosis
	Fibro myalgia
	Lupus or autoimmune disease
	Chronic disease
	Chronic fatigue
	Adrenal fatigue
	Multiple sclerosis
	Diabetes type I
	Diabetes type II
	Hypoglycemia
	Insulin Resistance
	Thyroid disease Hypo ____ Hyper ____
	Addisons disease or Cushings disease
	Kidney disease

Exercise History (Check all that apply)

	I don't exercise
	I have a very physical job so I don't exercise in addition
	I exercise every day for ____ minutes
	I exercise more than three times a week for over 50 minutes
	Normal daily activity is what I consider exercise
	I am a long distance runner
	I lift weights _____ times a week
	Other:

Diet (Check all that apply)

	I eat anything I want
	I don't eat much but gain weight anyway
	I have gained weight in my belly since I turned 40
	I eat a balanced diet, 3 times a day
	I eat 6 small meals a day
	I don't eat wheat (gluten intolerance)
	I limit carbohydrates
	I eat a low fat diet
	Atkins/South Beach Diet
	Vegan/Vegetarian
	Other:

I attest that all the information I give is true.

Print Name: Signature: Date:

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Weight Loss

Weight Loss Fee Schedule

Consultations (45 minutes):	$200
Follow up Consultations:	$150

*Actual cost may vary based on your individual treatment plan.

* Email will be used for most patient communication, unless otherwise discussed

Payment is due at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I understand that BioBalance® Health is **not a Medicare provider** and services provided by BioBalance® Health are not covered by Medicare.

I acknowledge that BioBalance® Health has no contracts with any insurance companies and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name: Signature: Date:

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Communication

Consent to Communicate

Please indicate the ways you consent for BioBalance Health to communicate with you

	Can contact (Yes/No)	Can leave message (Yes/No)
Cell Phone		
Home Phone		
Work Phone		
Email		
Text Message		

Do we have permission to speak with spouse/partner? Yes_____ No_____

Do we have permission to leave a message with spouse/partner? Yes_____ No_____

If yes, please list name(s) and relationship _____

Print Name: Signature: Date:

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Patient Records

Copying and Faxing Records, Forms, Financial Summaries, etc.

BioBalance Health collects a $35 fee for all copying or faxing of records, lab results, insurance forms, and financial summaries for tax purposes.

A signed release form is required before BioBalance Health will send, fax, email, etc. any medical records or information.

We will require a credit card prior to copying or faxing any of your forms, and will charge the card immediately. The time frame for copying is two weeks. Requests from life or disability insurance companies will also be charged to you and you may request reimbursement from the company.

Print Name: Signature: Date:

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HIPAA

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. We are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy.

I attest that all the history I give is true and I understand that this consent shall remain in force from this time forward.

Print Name: Signature: Date:

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