

## *Female Weight Loss Program*

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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 with 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](mailto: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.



# Female New Patient Questionnaire

## Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
SSN/Driver's License Number:			Marital Status:
Email:			
Address:			City:
State:	Zip:	Age:	Date of Birth:
Referred by:		Primary Care Physician:	
OBGYN:		Number of Children:	
Last Menstrual Period:		Number of Pregnancies:	
Occupation:		Employer:	
Office you will be Visiting: <input type="checkbox"/> St. Louis <input type="checkbox"/> Kansas City			
May we Contact you by: <input type="checkbox"/> Text <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Email <input type="checkbox"/> Office Phone			

## Emergency Contact Information

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

# Female New Patient Questionnaire

## Current Medications (List all current medications)

Drug	Dose	How Often?

## Supplements (List all current supplements)

Supplement	Dose	How Often?

## List all Allergies and Reactions (Food, Drug, etc.)


# Female New Patient Questionnaire

## History of Present Illness/Symptoms (check all that apply)

Low or No Sex Drive (Libido)
Fatigue or Lack of Energy
Infrequent or Absent Orgasms
Depression
Anxiety
Change in Mood or Irritable
Insomnia
Memory Loss or Foggy Thinking
Feeling Hopeless
Low or No Motivation
New Migraine Headaches
Decreased Muscle Mass & Strength
Joint Aches/Arthritis
Dry Eyes
Poor Balance & Coordination
Weight Gain
Belly Fat
Ringing in Ears
Difficulty Taking Oral Birth Control Pills
Other:

Hot Flashes or Night Sweats
Dry Vagina
Painful Intercourse
Heavy or Irregular Periods
Height has Decreased, Osteoporosis, or Osteopenia
Bladder Spasms
Bladder Infections
PMS
Felt Better Pregnant
Dry Skin
Constipation
Thinning Eyebrows/Eyelashes
Thinning Hair
Cold All of The Time
Swelling All Over Body
Brittle Nails
Ache All Over
Poor Immunity
Snoring
Other:

## Birth Control Method (Check all that apply). You must be in menopause, have had a hysterectomy, or use birth control to use hormone pellet therapy

Menopause
Hysterectomy
Tubal ligation
Birth control pills
Abstinence
Same sex partner

Vasectomy
Mirena IUD
Other IUD
Other:

# Female New Patient Questionnaire

## Past Surgeries (List year of surgery)

Year	Surgery
	D&C
	Gastric Bypass, Lap Band, or Other Surgery for Weight Loss
	Hysterectomy (Uterus Removed)
	Joint Replacement
	Open Heart Surgery or Stents
	Ovaries Removed
	Pacemaker
	Uterine Ablation
	Other Surgeries:

## Habits (Check all that apply)

	Smoking Cigarettes or Cigars
	Smoked in the past - enter years you smoked?
	I Drink More Than 10 Drinks of Alcohol/Week
	I am a Recovering Alcoholic
	I drink everyday
	I Use or Have Used Marijuana in Past Year
	I Use or Have Used Cocaine
	I Use or Have Used Heroin
	Other Habits

## Past Medical History (Check all that apply)

	ADD or ADHD
	Addison's Disease
	Adrenal Fatigue
	Alcoholism, AA, Drug Dependence
	Arthritis
	Autoimmune Disease (Rheumatoid, Lupus, etc.)
	Blood Clot/Pulmonary Embolism
	Breast Cancer
	Colon Cancer
	Concussion
	Contact Sports
	Cushing's Disease
	Depression/Anxiety
	Diabetes Type I
	Diabetes Type II
	Emphysema/COPD
	Fatty Liver Disease
	Fibromyalgia
	Glaucoma
	Heart Arrhythmia
	Heart Attack
	Heart Murmur
	Hemochromatosis
	Hepatitis

	High Blood Pressure
	High Cholesterol
	HIV or AIDS
	Hyperthyroid
	Hypothyroid
	Insulin Resistance
	In Vitro Fertilization (IVF) or other fertility
	Kidney disease
	Manic Depression or Bipolar Disorder
	Multiple Sclerosis (MS)
	Narcolepsy
	Osteopenia or Osteoporosis
	Ovarian Cancer
	Overweight or Obese
	Polycystic Ovarian Syndrome (PCOS)
	Restless Leg Syndrome (RLS)
	Schizophrenia
	Seizures or Epilepsy
	Sleep Apnea
	Stroke
	Tuberculosis (TB)
	Uterine cancer
	Other Problems/cancer:

# Female New Patient Questionnaire

## Social History (Check all that apply)

<input type="checkbox"/>	I am in menopause
<input type="checkbox"/>	I am still fertile
<input type="checkbox"/>	I have completed my family
<input type="checkbox"/>	I have permanent birth control
<input type="checkbox"/>	I am married or in a committed relationship
<input type="checkbox"/>	I am sexually active
<input type="checkbox"/>	I want to be sexually active
<input type="checkbox"/>	My sex life has gotten worse after 40
<input type="checkbox"/>	My sex life is better than before 40

<input type="checkbox"/>	I am heterosexual
<input type="checkbox"/>	I am homosexual
<input type="checkbox"/>	I am bisexual
<input type="checkbox"/>	I have a new partner in the last 3 years
<input type="checkbox"/>	My sex life is good
<input type="checkbox"/>	My sex life has gotten worse
<input type="checkbox"/>	I have never had an orgasm
<input type="checkbox"/>	Other:

## Exercise History (Check all that apply)

<input type="checkbox"/>	I don't exercise
<input type="checkbox"/>	Normal daily activity is what I consider exercise
<input type="checkbox"/>	I have a very physical job
<input type="checkbox"/>	I exercise daily for 45min or more
<input type="checkbox"/>	I exercise 3-5x/week for 45min or more
<input type="checkbox"/>	I lift weights
<input type="checkbox"/>	I am a long-distance runner, biker, or triathlete
<input type="checkbox"/>	Other:

## Diet (Check all that apply)

<input type="checkbox"/>	I eat anything I want
<input type="checkbox"/>	I don't eat much and gain weight anyway
<input type="checkbox"/>	I have gained weight in my abdomen
<input type="checkbox"/>	I do not eat wheat (gluten sensitivity/intolerance)
<input type="checkbox"/>	I eat a low carb diet
<input type="checkbox"/>	I eat a low-fat diet
<input type="checkbox"/>	I eat 3 meals a day
<input type="checkbox"/>	I eat 6 small meals a day
<input type="checkbox"/>	Vegan/Vegetarian
<input type="checkbox"/>	Intermittent Fasting
<input type="checkbox"/>	Keto Diet
<input type="checkbox"/>	Atkins/South Beach Diet
<input type="checkbox"/>	Weight Watchers
<input type="checkbox"/>	Other Diet Information:
<input type="checkbox"/>	Previous Diets Tried:

Current Weight: \_\_\_\_\_ (lbs)

Current Height: \_\_\_\_\_ (ft, in)

Goal Weight: \_\_\_\_\_ (lbs)

Current Dress/Pant Size: \_\_\_\_\_

Goal Dress/Pant Size: \_\_\_\_\_

# Female New Patient Questionnaire

## Preventative Medical Care (Check all that apply)

<input type="checkbox"/>	PCP Visit in the last year
<input type="checkbox"/>	OBGYN Visit in the last year
<input type="checkbox"/>	Urologist Visit in the last year
<input type="checkbox"/>	Mammogram in the last year
<input type="checkbox"/>	DEXA or Bone Density Scan in the last year
<input type="checkbox"/>	Pelvic Ultrasound in the last year
<input type="checkbox"/>	Colonoscopy in the last 10 years
<input type="checkbox"/>	Other:

## Hormone Replacement I have used (Check all that apply)

<input type="checkbox"/>	Oral pills synthetic (Ogen, Premarin, Estrace, etc.)
<input type="checkbox"/>	Patch
<input type="checkbox"/>	Vaginal ring
<input type="checkbox"/>	Other:
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

## Bioidentical Hormone replacement I have used (Check all that apply)

<input type="checkbox"/> Pellets	<input type="checkbox"/> Shots	<input type="checkbox"/> Troches	<input type="checkbox"/> Patch	<input type="checkbox"/> Pill
<input type="checkbox"/>	Creams/gels applied on the skin or in the vagina			
<input type="checkbox"/>	Sublingual or buccal tablets (dissolve in the mouth)			
<input type="checkbox"/>	Previous Growth Hormone Replacement			
<input type="checkbox"/>	Other:			

## Family History (Check all that apply)

<input type="checkbox"/>	Autoimmune Disease
<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	Breast Cancer
<input type="checkbox"/>	Colon Cancer
<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Diabetes, Type I
<input type="checkbox"/>	Diabetes, Type 2
<input type="checkbox"/>	Heart Attack or Heart Disease

<input type="checkbox"/>	Hemochromatosis
<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Prediabetes
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Thyroid Disease – high or low
<input type="checkbox"/>	Uterine Cancer
<input type="checkbox"/>	Other:

**I attest that all the information I give is true.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **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.

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Print Name:

Signature:

Date:



**Consent to Communicate**

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

	<b>Can contact (Yes/No)</b>	<b>Can leave message (Yes/No)</b>
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:

**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 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](http://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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**BioBalance Health – Quest Diagnostics**

**Quest Account STL 78300024**

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

Kathy C. Maupin M.D.

Bill Insurance

Fax Results to (314) 218-3999

Draw Before 9:00 AM

FASTING

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Diagnosis Codes: N95.1, E34.9, R53.83, Z00.8, E66.3**

Female (20 test)

10231 CMP

7600 Lipid Panel

6399 CBC w/Diff

10124 Cardio CRP

16293 IGF-1

4212 Cortisol AM

615 LH

470 FSH

746 Prolactin

23244 Estrone

30289 Estradiol Ultrasensitive

785 ABO Group

899 TSH

866 T4 free

34429 T3 free

18944 Testosterone free

457 Ferritin

31789 Homocysteine

561 Insulin (Fasting)

496 Hemoglobin A1C

Signature: 

Total Test Ordered: 20

**BioBalance Health – LabCorp**

**LabCorp Account #24863400**

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

Kathy C. Maupin M.D

Bill Insurance

Fax Results to (314) 218-3999

Draw Before 9:00 AM

FASTING

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Diagnosis Codes:** N95.1, E34.9, R53.83 Z00.8, E66.3

**Female (20 test)**

322000 CMP

303756 Lipid Panel

005009 CBC w/Diff

120766 Cardio CRP

010363 IGF-1

104018 Cortisol AM

004283 LH

004309 FSH

004465 Prolactin

004564 Estrone

140244 Estradiol Ultrasensitive

006056 ABO Group

004259 TSH

001974 T4 free

010389 T3 free

070195 Testosterone Free & Total

004598 Ferritin

706994 Homocysteine

004333 Insulin (Fasting)

001453 Hemoglobin A1C

Signature: 

Total Test Ordered: 20

# BioBalance Health – Lab Rec

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

Kathy C. Maupin M.D.

Bill Insurance

Fax Results to (314) 218-3999

Draw Before 9:00 AM

FASTING

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Diagnosis Codes: N95.1, E34.9, R53.83, Z00.8, E66.3**

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**Female (20 test)**

CMP

Lipid Panel

CBC w/Diff

Cardio CRP

IGF-1

Cortisol AM

LH

FSH

Prolactin

Estrone

Estradiol Ultrasensitive

ABO Group

TSH

T4 free

T3 free

Testosterone free

Ferritin

Homocysteine

Insulin (Fasting)

Hemoglobin A1C

Signature: \_\_\_\_\_



Total Test Ordered: 20