Luminiv Wellness

2235 Cedar Ln #302 Vienna, VA 22182 | 44121 Harry Byrd Hwy #250 Ashburn, VA 20147 | 2010 A Opitz Blvd Woodbridge, VA 20191 | 3575 Old Washington Rd, Ste C Waldorf, MD 20602

www.LuminivWellness.com Ph: (703) 494-1020 Ph: (240) 204-6116 Fax: (703)255-6011

PATIENT REGISTRATION FORM

□ **New** □ **Changes/Updates**
(If Changes/Updates – Please only include the new information and if applicable the effective date)

PERSONAL INFORMATION

Patient's Last Name: _____ Middle: _____ First: _____

Last 4 of SSN#: _____ DOB: ____/____/____ Age: _____ Sex □ F □ M Marital Status: □ M □ S □ W □ D

Race: _____ Ethnicity: (Check one) □ Hispanic/Latino □ non-Hispanic/Latino □ Unknown □ Decline to Specify

Home Address: _____ City: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

Primary Care Physician Name and Telephone Nbr._____

Local Pharmacy Name: _____ Telephone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Patient Email: _____ Preferred way of communication: _____

Emergency Contact Name: _____ Relationship: _____ Telephone: _____

Employer: _____ Occupation: _____

Employment Address: _____ City: _____ State: _____ Zip: _____

BILLING AND INSURANCE INFORMATION – We scan your ID and insurance card.

1. Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: ____/____/____ SSN#: _____

Relationship to Insured: □ SELF □ SPOUSE □ CHILD □ OTHER _____

2. Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: ____/____/____ SSN#: _____

Relationship to Insured: □ SELF □ SPOUSE □ CHILD □ OTHER _____

3. Tertiary Insurance: PLEASE LER STAFF KNOW IF YOU HAVE ANY TERTIARY INSURANCE

Whom Can we Thank for the Referral?

☐ Physician ☐ Insurance ☐ Business ☐ Family ☐ Friend ☐ Search Engine ☐ Other Name: _____

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Which Physicians are currently treating you? Please give us their names, address and Phone numbers to allows us to work with them for your safety.

Specialty	Name	Phone Number	Address
Primary Care			

Motivation/Goal

What is your main reason for weight management? ***Check all that apply:***

□ I am self-motivated
□ Health issues and/or recommendation from a physician
□ Encouragement from a family member
□ Other_____

How do you think weight management will help you? ***Check all that apply:***

□ Improved Health
□ Improved Fitness
□ Improved Quality of life
□ Improved appearance
□ Other_____

What treatment options are you open to? ***Check all that apply:***

□ Lifestyle changes only
□ Lifestyle changes and weight loss medications
□ I'm open to surgical weight loss

Apart from the above, please describe your general health goals and improvements you would like to make:

_____

Do you feel you will need medication for appetite suppression? □ YES □ NO

Current Symptoms (check any if present)		
□ Low Appetite	□ Increased Appetite	□ Decreased Appetite
□ Chills	□ Fatigue	□ Fever
□ Sweats	□ Other _____	□ Other

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Weight History

What is your Target weight? _____ lbs.

Normal weight upon birth? □ Yes □ No

Normal weight during childhood? □ Yes □ No

Genetic/Family History of Obesity: *Check all that apply*

□ I was excessively hungry as a child.

□ Obesity started early and has been progressive during my life

□ There is a strong family history of obesity.

□ Other _____

When were you last at your Target weight? _____

Highest adult weight_____lb.

Lowest adult weight_____lb.

Other potential reasons for weight gain: *Check all that apply*

□ Work/Shift related activity/stress

□ Smoking cessation

□ Medications

□ Post-partum weight retention (For Female patien only)

□ Menopause (For Female patients only)

Please indicate the weight loss methods you have tried previously and the results below:

Weight Loss Method (Diet Name)	Result	How long was the weight maintained?	Why did you stop?	Problems faced

Are you currently working with a Registered Dietitian? □ Yes □ No
If yes, please indicate Name and Contact Information: _____

What do you think that you struggle with when it comes to your diet (i.e. potion sizes, stress, emotional eating, etc.): _____
_____

Previous Use of Weight Loss Medications (please leave blank of none):

Name of Medication	Dosage	Frequency and Route	Amount of Weight Loss	Side Effects
□ Phentermine				
□ Metformin				
□ Topiramate (Topamax)				
□ Wellbutrin (bupropion)				
□ Qsymia (Phentermine/Topiramate)				
□ Contrave (naltrexone/bupropion)				
□ GLP-1 Agonist (Wegovy/Semaglutide)				
□ Zepbound (tirzepatide)				
□ SGLT-2 inhibitor				
□ Other				

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Medical History: (check all that apply and add any others in last 5 boxes in the last row)

□ Polio	□ Thyroid Disease	□ Bleeding Disorder	□ Jaundice	□ Alcohol Abuse
□ Tonsillitis	□ Pneumonia	□ Ulcers	□ Pleurisy	□ Typhoid Fever
□ Kidney Disease	□ Cholera	□ Anemia	□ Liver Disease	□ Blood Transfusion
□ Lung Disease	□ Arthritis	□ Tuberculosis	□ Chicken Pox	□ Gallbladder
□ Rheumatic Fever	□ Measles	□ Eating disorder	□ Nervous Breakdown	□ Osteoporosis
□ Psychiatric Illness	□ Mumps	□ Malaria	□ Gout	□ Whooping Cough
□ Heart Disease	□ Scarlet Fever	□ Cancer	□ Heart valve disorder	□ Drug Abuse
□ Glaucoma	□ Palpitations	□ Chest Pain	□ Headaches	□ Kidney Stones
□ Seizures	□ Head trauma	□ Radiation to brain	□ Pancreatitis	□ Thyroid cancer
□	□	□	□	□

General Health History: Please indicate if you have had of any of the following:

High blood pressure? □ YES □ NO	Pre-diabetes or diabetes □ YES □ NO	Heart attack or chest pain □ YES □ NO
Frequent headaches or migraines □ YES □ NO	Sleep apnea □ YES □ NO	Constipation: □ YES □ NO
Swelling of feet: □ YES □ NO	Glaucoma: □ YES □ NO	Snoring: □ YES □ NO

Are you allergic to any medications? □ YES □ NO If yes, please specify the medication(s) and reaction: _____

_____

_____

Smoking habits:

□ I have never smoked cigarettes, cigars, or a pipe.

□ I quit smoking _____years ago and have not smoked since _____.

□ I am trying to quit smoking

□ I quit smoking cigarettes at least one ___ ago and now smoke cigars or a pipe without inhaling smoke

□ I smoke 30 cigarettes per day (1 and ½ packs)

□ I smoke 20 cigarettes per day (1 pack)

□ I smoke 40 cigarettes per day (2 packs)

Overall Health (check all that apply)
Eyes → last check up (date or how long ago) _____. □ Blurred vision □ Double vision □ Cataracts □ Eye pain □ Redness □ Glaucoma □ Recent change in vision
Ears → last check up (date or how long ago) _____. □ Decreased hearing □ Pain □ Ringing □ Use of hearing device
Nose → □ Allergies □ Congestion □ Obstruction

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Throat → □ Enlarged tonsils □ Snoring □ Sore throat □ Trouble swallowing

Cardiovascular → □ Chest pain or pressure □ Fainting or black out spells □ Heart murmur □ Palpitations (racing heart or skipped beats) □ Shortness of breath □ Trouble lying flat □ Swelling in the legs or feet

Respiratory → □ Congestion □ Cough □ Rattling □ Wheezing

Stomach & Gastrointestinal → Last colonoscopy (year) _____.
□ Bloody stools □ Cramps □ Constipation □ Diarrhea □ Heartburn or reflux □ Nausea □ Pain □ Vomiting

Muscles, Joints, & Bones → □ Arthritis □ Back pain □ Morning stiffness □ Muscle pain □ Muscle weakness □ Joint pain or stiffness (where): _____

Skin → □ Acne □ Itching □ Lump, nodule, or mole (where)_____ □ Nail changes _____
□ Rash (where) _____

Neurologic → □ Forgetfulness □ Numbness □ Weakness

Psychiatric → □ Anxiety □ Crying spells □ Depression □ Insomnia □ Panic attacks □ Rage or temper problems □ Suicidal feelings

Hormones → □ Excessive hunger □ Excessive thirst □ Decreased libido □ Hoarseness □ Recent hair growth

Hormones (Female) → Last Gynecological exam _____.□ Change in periods □ Blood and circulation □ Clotting problems □ Easy bruising

Breast → Last mammogram _____□ Discharge □ Lump □ Pain □ Rash or redness

Allergy & Immunology → □ Frequent infection □ Seasonal allergies

FAMILY HEALTH HISTORY

PLEASE NOTE THE ILLNESS OF THOSE LIVING OR DEAD. PLEASE MARK AN "X" IF YES, LEAVE BLANK FOR NONE

HISTORY	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILDREN	OTHER
If Living, Age							
If Dead, Age at Death							
Overweight?							
Glaucoma							
Asthma							
Heart disease							
High Blood Pressure							
Kidney disease							
Diabetes							
Tuberculosis							
Bipolar Disorder							
Stroke							
Other: _____							

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Sleep History

I sleep an average of _____ hours at night.

I sleep at _____ am/pm and wake up at _____ am/pm.

I wake up _____ times a night for _____

My last drink of the day is at _____

I have been told I quit breathing while sleeping? □ YES □ NO

I fall asleep or feel sleepy while driving, riding in a car >30 min, reading, or watching TV? □ YES □ NO

If yes, describe: _____

I have had a Sleep Study: □ Yes □ No

If Yes, When and Where? _____

I have been diagnosed with Obstructive Sleep Apnea (OSA):

□ Yes (please SKIP Sleep Apnea questionnaire) □ No

I currently use a CPAP or other device for OSA: □ Yes □ No

Sleep Apnea Questionnaire (Please skip if previously diagnosed with OSA) (1 point for each yes)

1. I snore loudly: □ Yes □ No	2. My BMI is > 35: □ Yes □ No
3. I feel tired, fatigued, or sleepy during the daytime: □ Yes □ No	4. My age is >50: □ Yes □ No
5. I have been observed me stop breathing, gasp, or chock when I slee □ Yes □ No	6. My neck circumference is >17 inches (male) or >16 inches (female): □ Yes □ No
7. I have a diagnosis or are treated for high blood pressure: □ Yes □ No	8. I am a male: □ Yes □ No
Score: ____/8	

Stress/Mood History

Behavior Style: (answer only one)

□ I am always calm and easy going

□ I am seldom calm and persistently drive for advancement.

□ I am sometimes calm with frequent impatience.

□ I am hard-driving and can never relax

My stress level during the past year on a scale of 1 to 10: _____

When I feel stressed, I tend to

_____

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The main cause of my stress is _____

I have thoughts about harming myself or wanting to die: □ Yes □ No

I have done self-harming behaviors such as cutting myself: □ Yes □ No

I have been to the ER or hospitalized for mental health reasons: □ Yes □ No

I have alcohol or substance abuse problems (including prescription abuse) : □ Yes □ No

PHQ-9 (Depression Questionnaire) (Please Circle appropriate number and add the total at the bottom)

Over the last 2 weeks how often have you been bothered by any of the following	**Not at all**	**Several days**	**More than half of the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself/family down	0	1	2	3
Trouble concentrating on things such reading or watching television	0	1	2	3
Moving or speaking so slowly that people have notice or being so fidgety or restless that you have been moving around a lot more.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself	0	1	2	3

Total Score: _____ / 27

Physical Activity History

Activity Level: (answer only one)

□ Inactive → No regular physical activity, with a sit-down job

□ Light activity → No organized physical activity during leisure time.

□ Moderate activity → occasionally in activities such as weekend golf, tennis, jogging, or swimming.

□ Heavy activity → consistent lifting, stair climbing, heavy construction, etc. or regular.

□ Vigorous activity → participation in extensive physical exercise for at least 1 hour 4 times per week

At work I am □ Constantly moving. □ Somewhat active. □ Not active

I exercise regularly □ Yes □ No

Type of exercise that I usually do: _____

Amount of time I exercise daily: _____ minutes.

Number of times I exercise in a week _____

I have been unable to exercise because? _____

The physical activities I enjoy are _____

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Other activities that are limited by my weight: _____

Has any doctor or other healthcare 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 of the 2 exercise related questions, please explain: _____

Nutrition Evaluation:

Present weight: _____Height (no shoes): _____Desired weight: _____

In what time frame would you like to be at your desired weight? _____

Birth weight: _____Weight at 20 years of age: _____Weight 1 year ago: _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (Give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when? _____

Is your spouse, fiancée, or partner overweight? □ YES □ NO If yes, by how much is he or she overweight? _____

How often do you eat out? Please specify: _____

What restaurants do you frequently go to? Please specify: _____

How often do you eat "fast foods"? Please specify: _____

Who normally plans meals? _____Who cooks? _____

Who grocery shops? _____Do you use a shopping list? □ YES □ NO

What time of the day and what day do you shop for groceries? _____

Food allergies? □ YES □ NO If yes, please provide details: _____

Food dislikes? □ YES □ NO If yes, please provide details: _____

Do you crave food □ YES □ NO If yes, please provide details: _____

Specific time of the day or month do you crave food? □ YES □ NO If yes, please provide details: _____

Do you drink coffee or tea? □ YES □ NO If yes, how many cups a day: _____

Do you drink soft drinks? □ YES □ NO If yes, how many daily: _____Diet or Regular: _____

Do you drink alcohol? □ YES □ NO If yes, how much per day? _____

Do you use a sugar substitute? □ YES □ NO

Do you wake up hungry during the night? □ YES □ NO If yes, what do you normally eat: _____

What are your worst food habits: _____

Do you binge eat? □ YES □ NO If yes, how often: _____

Have you ever induced vomiting or taken laxatives or diuretics for weight loss? □ YES □ NO

Have you ever been diagnosed with bulimia? □ YES □ NO

Have you ever been diagnosed with Anorexia Nervosa? □ YES □ NO

Snack habits? □ YES □ NO If yes, please specify:_____

What time of day & how much: _____

When you are under a stressful situation at work or family related, do you tend to snack more? □ YES □ NO

Explain:_____

Do you think you are currently undergoing a stressful situation or are emotionally upset? □ YES □ NO

Explain: _____

Typical Breakfast: _____ What time: _____

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Where: _____With whom: _____

Typical Lunch: _____What time: _____

Where: _____ With whom:_____

Typical Dinner: _____What time:_____

Where: _____With whom:_____

Please write down everything you ate in the previous 24 hours starting with yesterday morning (Please include alcohol and sugar-free beverages as well)

Meal	Time	Food and Drinks Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Do you have excessive hunger within 1-2 hours of having a regular meal? □ Yes □ No

At times I eat when I am not hungry □ Yes □ No

If yes, describe when this happens and why? _____

I eat for comfort when I am stressed or emotional □ Yes □ No

If yes, describe when this happens and why? _____

There are times when I eat, and it feels like I can't stop □ Yes □ No

If yes, describe when this happens and why? _____

I try to manage my weight by vomiting, using laxatives, diuretics, or excessive exercise □ Yes □ No

If yes, when was the last time? _____

Sometimes I find food on my bed which I do not remember eating □ Yes □ No

If yes, how often does this happen?_____

I eat late at night, or I wake up at night and eat □ Yes □ No

Please list foods that you eat frequently _____

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Gynecologic History:

Date of last gynecologic checkup: _____

Menstrual History:

Menstrual Onset Age: _____ Regular: □ YES □ NO

If periods are not regular (not regular, excessively heavy, etc.), Describe: _____

Is there any pain associated? □ YES □ NO Date of last menstrual period: _____

Have you ever been diagnosed with polycystic ovary syndrome? □ YES □ NO

Pregnancy History:

Number of Pregnancies: _____ Dates: _____

Natural delivery or C-Section (specify): _____

Is there any chance of pregnancy now? □ YES □ NO

Complications of pregnancy (e. g. gestational diabetes, preeclampsia, eclampsia, etc.)

Describe: _____

Other:

Hormone Replacement Therapy? □ YES □ NO Please specify: _____

Current contraceptive/Birth control use: □ Oral contraception

□ IUD (Mirena, copper IUD) □ Tubal ligation (tubes tied)

□ Hysterectomy and/or ovaries removed □ Other _____

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PATIENT RECORD OF DISCLOSURES

The HIPAA Privacy rules give individuals the right to request a restriction of uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

Patient Information

Patient Name: _____ Date: _____

DOB: _____

I wish to be contacted in the following manner (check all that apply):

☐ Patient Portal

□ Mobile telephone _____

- □ Okay to Leave Message with detailed information
- □ Leave message with call-back number only

□ Home telephone _____

- □ Okay to Leave Message with detailed information
- □ Leave message with call-back number only

□ Work telephone _____

- □ Okay to Leave Message with detailed information
- □ Leave message with call-back number only

□ Other: _____

□ Personal Representative of Patient:

I hereby give permission to the person(s) listed below to authorize treatment and to receive information about the care of the above-named patient.

Name: _____ Relationship to Patient _____

Name: _____ Relationship to Patient _____

Patient /Parent or Guardian Signature: _____ Date: _____

The HIPAA privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Note: Uses and disclosures of TPO may be permitted without prior consent in an emergency.

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POLICIES ACKNOWLEDGEMENT AND AUTHORIZATION FORM

PATIENT INFORMATION

Last Name: _____ M.I: _____ First Name: _____

Sex: ☐F ☐M DOB: _____/_____/_____

Patient's Address: _____ Apt#: _____

State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

DECLARATION

I was given a copy and have read and understand the LUMINIV WELLNESS Notice of Privacy Practices, LUMINIV WELLNESS Weight Loss consent form, LUMINIV WELLNESS Weight-Loss Consumer Bill of Rights, LUMINIV WELLNESS PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS, LUMINIV WELLNESS Hours of Operation and Cancellation Policy, and I agree to be bound by these terms Signing this declaration gives LUMINIV WELLNESS the same rights as signing each of the individual named documents in this declaration.

_____ _____

Signature of Patient Date

_____

Print Name

_____ _____

Signature of Responsible Party/Guardian Printed Name/Relationship

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Notice of Privacy Practice

This notice describes the way in which medical and personal information pertaining to you may be used and disclosed. It also explains how you can access your health information. Please review it carefully and sign the attached acknowledgement receipt at the bottom of this notice and return it to the receptionist.

At LUMINIV WELLNESS, the staff is committed to the protection of your private health information. Within our office access to your information is limited to those employees who need access in order to perform their jobs.

LUMINIV WELLNESS may use and disclose protected health information in order to facilitate treatment, collect payments and for internal healthcare operations. Examples of these include but are not limited to referral to other healthcare providers, life insurance physicals, and home healthcare agencies. Payment examples include your health insurance provider for claims and coordination of benefits, workman's compensation, or similar programs, Collection's agencies, etc. Healthcare operations include auditing of records and internal quality control.

LUMINIV WELLNESS is required by law to use and/or disclose protected health information without the patients' written consent or authorization in certain circumstances. These include reporting a crime, responding to a subpoena, warrant or court order; public health officials concerned with controlling disease, disability, and injury.

LUMINIV WELLNESS may use or disclose protected health information to your personal representative whom you have authorized to act on your behalf in making decisions related to your health care.

LUMINIV WELLNESS will contact patients at phone numbers provided to us by the patient in order to give appointment reminders or other information regarding treatment and/or tests results.

LUMINIV WELLNESS will not use or disclose a patient's protected health information as is described in this notice without the individual's written authorization. This authorization may be revoked at any time in writing. Exceptions are those described above as required by law.

LUMINIV WELLNESS will abide by this notice, at the time of disclosure. We reserve the right to revise the terms of this notice and make new provisions effective for all protected health information we maintain.

LUMINIV WELLNESS will keep a posted copy of our current privacy practices in our lobby area. Copies of this notice may also be obtained at any time in our office.

Any person/patient, who believes their privacy rights have been violated, may register a complaint with our practice administrator on 703-831-4207.

It is our office policy that no retaliatory action will be taken against any individual who submits a complaint of non-compliance of the privacy standards.

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You have the legal right to inspect copies of your protected health information. This requires a written, signed, and dated request. (as allowed by State law, reasonable copy fees may apply)

If you believe your health information is inaccurate or incomplete, you may request to amend your information. In the event that we deny your request, we will inform you of our reasons for such a denial in writing.

You have the legal right to request restrictions on certain uses of your protected health information as provided by 45CFR 154.522(a). By law we are not required to comply with a requested restriction.

Acknowledgement of Privacy Practices:

I have received a notice of privacy practices, outlining my rights regarding my protected health information and the specific ways in which my private health information may be used and disclosed as allowed under state and federal law.

Patient or legal representative: _____ Date_____

Relationship of above if not signed by patient_____

Luminiv Wellness

2235 Cedar Ln #302 Vienna, VA 22182 | **44121 Harry Byrd Hwy #250 Ashburn, VA 20147** | **2010 B Opitz Blvd Woodbridge, VA 20191** | **3575 Old Washington Rd, Ste C Waldorf, MD 20602**

www.LuminivWellness.com Ph: (703) 494-1020 Ph: (240) 204-6116 Fax: (703)255-6011

WEIGHT LOSS CONSENT FORM

I _____authorize Dr. Sree L. Gogineni and her staff at LUMINIV WELLNESS to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low-calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature. I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there is certain health risks associated with remaining overweight or obese. Risks of this program may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if any concerns I have about this form have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form. ***If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.***

Date_____ Time_____

Witness_____Patient_____

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NUTRITION COUNSELING PAYMENTS POLICY

At Capital Area Physician Weight & Wellness Center, we are committed to helping you achieve your health and wellness goals. As part of this commitment, we offer professional nutrition counseling services. However, it is important to note that many insurance plans do not cover nutrition counseling services unless there is an underlying, supported diagnosis that meets their specific coverage criteria.

To ensure transparency and a clear understanding of potential out-of-pocket costs, please review and sign the following policy regarding payment for nutrition counseling services:

Nutrition Counseling Fees

1. **Initial Session Fee:**
   - $190 per session
2. **Follow-Up Session Fee:**
   - $125 per session
3. **Package Option:**
   - $475 for 4 sessions (a savings of $65 compared to individual session pricing).

Insurance Coverage Disclaimer

We will make every effort to verify insurance benefits and submit claims for nutrition counseling services. However, you are responsible for understanding your insurance policy and whether it covers nutrition counseling. If your insurance denies coverage, you will be personally responsible for the fees listed above.

Please note that any charges not covered by your insurance must be paid at the time of service unless other arrangements have been made with our office.

Acknowledgment and Agreement

By signing this policy, you acknowledge that:

- You understand that insurance may not cover nutrition counseling services unless an underlying supported diagnosis is present.
- You agree to pay the fees listed above for nutrition counseling services if your insurance does not provide coverage.
- You understand and agree to pay for any portion of services not covered by your insurance, including the full session fees if necessary.

Patient Name: _____

Patient Signature: _____ **Date:** _____

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Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 1/2 pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have the right to ask questions about the potential health risks of the program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program.

I have read the above:

Patient's Signature: _____ Date_____

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Release of Medical Records

I give permission for my medical records (blood work, chart, EKG) to be released to:

_____

_____

_____

Patient's Name_____Signature_____Date_____

BEFORE" AND "AFTER" PHOTOS

I_____, give my permission for Luminiv Wellness to take my "before" and "after" photographs. (***Photographs will not be used for advertising without patient permission)***

Signature_____

Date: _____

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PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

1. I_____ (patient or patient's guardian) authorize Dr. Sree L. Gogineni and her staff at LUMINIV WELLNESS to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As an obesity management certified physician, I have found appetite suppressants helpful for periods far more than 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer-term studies, and recommendations of university-based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"As an obesity management certified physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of the side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. A balanced calorie counting program or/and exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include nervousness, sleeplessness, headaches, dry mouth,

weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees, and feet. I understand these risks may be modest if I am not very overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving appetite suppressants.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE_____TIME_____

PATIENT_____WITNESS_____

(Can be signed by legal guardian if patient is a minor)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

Physician's Signature_____

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LUMINIV WELLNESS Hours of Operation and Cancellation Policy

We make every effort to make sure your visits are pleasant and efficient for you. Please make every effort to arrive at your appointment on time. If you are unable to make your scheduled time, just call and notify our office. (AFTER HOURS YOU CAN LEAVE A MESSAGE ON OUR PHONE) Or contact us through the patient portal. Our patient hours are as follow:

Monday 8 AM to 4:30 PM

Tuesday 8 AM to 4:30 PM

Wednesday 8 AM to 4:30 PM

Thursday 8 AM to 4:30 PM

Friday 8 AM to 4:30 PM

If you need to miss an appointment, please call 24 hours in advance to cancel to avoid a $50.00 no-show fee. Again, you can call after hours and leave a message on our answering machine. Our phone number is 703-494-1020 or Ph: 240-204-6116 and press #8 to leave a message.

I ACKNOWLEDGE THE ABOVE-MENTIONED NO-SHOW POLICY AND UNDERSTAND I WILL BE CHARGED $50.00 FOR FAILURE TO GIVE 24-HOURS NOTICE TO THE OFFICE OF CANCELLATION.

_____ _____

Signature DATE

_____

Name