the center for medical weight loss

CosMedic SKINCARE

JODIE REINERTSON, MD

# Thank you for joining us at The Center for Medical Weight Loss! We are glad you are here!

**~ Please check the FIRST way in which you heard about us ~**

## ☐ Internet :

- □ Google.com
- □ Yelp.com
- □ Dermsnextdoor.com
- □ Latisse.com
- □ Sculptra Aesthetic website
- □ Isolaz Therapy – Stop the Pop Website
- □ The Center for Medical Weight Loss Website
- □ Citysearch.com
- □ Yahoo.com
- □ Bing.com
  - □ Radiesse.com
  - □ Thermage.com
  - □ Facebook
  - □ Other:

_____

## ☐ Magazine/Newspaper :

- □ Seattle Metropolitan Magazine
- □ Seattle Magazine
- □ UW Daily Newspaper
- □ Other:

_____

## ☐ Friends of CosMedic Skincare :

- □ Dress for Success
- □ Dr. Daniel McKay, DDS
- □ Cabrini Medical Tower
- □ Other:

_____

## ☐ Other : (please specify below)

- □ Friend: _____
- □ Relative: _____
- □ Other:

_____

# CosMedic Skincare and the Center for Medical Weight Loss

## PATIENT INFORMATION:

| | | | |
|---|---|---|---|
| **PATIENT NAME :** | | **DATE OF BIRTH:** | |
| **ADDRESS:** | **CITY & STATE:** | | **ZIP CODE:** |
| **PREFERRED CONTACT NUMBER:** | **SECONDARY CONTACT NUMBER:** | **3RD CONTACT NUMBER:** | |
| **EMPLOYER:** | | **PARTNER/SPOUSE NAME:** | |
| **EMAIL ADDRESS:** | | *Your email address will only be used for in-office communication and will not be sold or given to any 3rd party individual or organization.* | |

☐ **PLEASE CHECK HERE IF YOU WOULD LIKE TO JOIN OUR *PATIENT RECOGNITION PROGRAM*. E-MAIL NEWSLETTER IS SENT ONCE A MONTH**

## RESPONSIBLE PARTY (Required for Minors):

| | |
|---|---|
| **NAME:** | **RELATION:** |
| **ADDRESS, CITY, STATE, ZIP:** | **CONTACT NUMBER:** |

## IN CASE OF EMERGENCY, PLEASE NOTIFY:

| | | |
|---|---|---|
| **NAME:** | **RELATION:** | |
| **HOME PHONE:** | **WORK PHONE:** | **CELL PHONE:** |

## FINANCIAL RESPONSIBILITY AGREEMENT

- We are not contracted with any insurance company; however, we can provide a superbill to submit to your insurance company for reimbursement. Ultimately, you will assume full financial responsibility.
- Payment is due at the time of service. We accept payment in the form of cash, AMEX, Visa, MasterCard & Discover.
- Payment plans are available through third party financing groups.
- NO SHOWS may be subjected to a fee of $50 if appointment is not cancelled at least 24 hours in advance.
- A deposit must be taken for major procedures. Sculptra Aesthetic procedures require a $250 deposit.

*I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold CosMedic Skincare responsible for verifying this information. I accept full financial responsibility for medical expenses incurred at the CosMedic Skincare for all services provided. In the event where it is necessary to refer my account to an attorney for collection, I am responsible for all fees and expenses.*

_____ _____/_____/_____

Signature (If under 18, must be signed by parent/guardian) Date

_____

If parent/guardian, print name

***[ Optional ]*** **Procedures or products of interest to you (please check all that apply)**

- ❑ Dermal Filler for accentuating facial features and correcting folds and wrinkles (Juvederm, Radiesse, and Sculptra)
- ❑ BOTOX for Wrinkles
- ❑ BOTOX for Excessive Sweating
- ❑ Laser Lipo for Body Sculpting
- ❑ Thermage for Skin Tightening
- ❑ Laser/Light Treatments for Treating Pigment and/or Age Spots
- ❑ HydraFacial MD to Promote Smooth, Healthy Skin
- ❑ Microdermabrasion
- ❑ Medical Weight Loss Program
- ❑ Permanent Make-up
- ❑ Sculptra Aesthetic for Collagen Production
- ❑ Sclerotherapy for Spider Veins
- ❑ Melanage Peel for Melasma
- ❑ Laser Hair Removal
- ❑ Skin Resurfacing with DOT Therapy
- ❑ Eyebrow Waxing or Tinting
- ❑ Chemical Peels
- ❑ Medical-Grade Skincare
- ❑ Other, Please Specify: _____

## PATIENT MEDICAL INFORMATION

Primary Physician: _____ Hospital/Clinic: _____

Last Physical: _____ Last Blood Work: _____

Drug Allergies: _____ Food Allergies: _____

List of Medications Currently Taking: _____

_____

Past Medical History: _____

Past Surgical History: _____

Family Medical History: _____

*Women* Menstrual Cycle is _____Regular or ____Irregular

#of Children: _____ □ On Birth Control □Planning Children □Pregnant □Nursing

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed by CosMedic Skincare and the Center for Medical Weight Loss. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-622-6444 or by requesting one at this office.

____/_____/____
Date

_____
Print Name

_____
Signature

# WEIGHT CONTROL QUESTIONNAIRE

*This form has been designed to assist you in organizing your thoughts regarding what you want to achieve with your customized weight loss program. By first filling out this questionnaire as completely as possible, and then reviewing it with Dr. Reinertson, you will learn what goals are reasonably attainable.*

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

What will happen if you don't lose that much weight or do not lose it quickly? How will you react? _____

_____

Do you understand the difference between fat loss and water loss? _____

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

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

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

Do you expect to be doing anything you are not doing now? (Describe in detail) _____

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

Will you be able to handle compliments about how you look when you are at your goal weight? _____

Will the "new you" pose a threat to any relationships?" (Please specify) _____

How will family and friends respond to the "new you?"_____

Do you expect to get a better job? _____

Will you get more respect from other people? (Who specifically)_____

Will you feel comfortable with these altered responses from others? _____

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

Will you have to be more sociable than you are now? _____

Will you have to assume any new responsibilities? (Please describe) _____

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

What do you expect to have to do to maintain your goal weight? _____

Will you continue to watch your food intake? _____ Exercise? _____

Continue with professional medical monitoring? _____ For how long? _____

Do you have any other expectations than those listed above? _____

If so, what are they? Please describe them in detail: _____

_____

**Patient Name:** _____ **Date:** ____/_____/____

# Appointment Cancellation Policy

**In an effort to provide the best service possible for all of our patients, we have the following cancellation policy for all appointments:**

We request 24-hour notice if you wish to cancel or reschedule your appointment. If you are booked for a major procedure, we request 72-hour notice. This enables us to respond to the higher demand over availability for appointments.

Patients who cancel or reschedule in less than the required time, or do not show for their scheduled appointments, will be charged a $50 fee since we were unable to offer that time to another patient.

Patients will either be charged the fee at their next visit or in special circumstances, they will be required to pay a $50 deposit to secure a future appointment.

The cancellation fee is non-refundable, non-transferrable, and due in full at the subsequent treatment date.

By signing below I agree that I was informed of this policy and I understand it.

**X**_____

_____
Print Name

Date: ____/_____/_____