Weill Cornell Medicine ┤NewYork-Presbyterian

Division of Endocrinology, Diabetes and Metabolism
Comprehensive Weight Control Center
1305 York Ave, 4th Floor
New York, NY 10065

Phone: (646) 962-2111
Fax: (646) 962-0159

NEW PATIENT WEIGHT REGISTRATION PACKET

Dear Patient,

Thank you for setting up your initial appointment.

Our office address is 1305 York Avenue, 4th Floor. Please arrive *15 minutes* prior to your appointment time. If you are unable to keep your appointment, we require at least 48 hours advance notice. If you have a virtual visit, please log into Zoom 10-15 minutes before the appointment time. You will receive an update once your provider joins the Zoom meeting and then you to have to click to join once more at that time. Please call the office if you encounter issues at **646-962-2111**.

Appointment Date: ____________________________ Appointment Time:______________________________

Clinician:

- ☐ Dr. Louis Aronne
- ☐ Dr. Jonathan Waitman
- ☐ Dr. Mohini Aras
- ☐ Dr. Sarah Barenbaum
- ☐ Dr. Alpana Shukla
- ☐ Dr. Beverly Tchang
- ☐ Dr. Eugene Lucas
- ☐ Dr. Sarah Schmitz
- ☐ Janet Feinstein, RD
- ☐ Ashley Kim, RD
- ☐ Morgan Dickison, RD

For your initial visit, the following documents are required and need to be emailed or faxed prior your visit or can be brought with you at the time of your scheduled appointment. Failure to do so can result in delay of care.

You can email the documents to: **WCM-Endo1305@med.cornell.edu**

REQUIRED NEW PATIENT DOCUMENTS:

1. ***Medical Documents:***
   a. Completed New Patient Registration Packet
   b. Fasting lab results within the last 12 months need to be conducted prior to your appointment (we do not provide lab requisition for new patients. It is recommended that patients obtain lab orders from a primary care provider or referring provider, failure to do so can result in delay of care):
      - **Comprehensive Metabolic Profile**
      - **Lipid Profile**
      - **Hemoglobin A1C**
      - **Vitamin D, 25-OH**
      - **CBC without Diff.**
      - **Thyroid Profile (TSH, free T4)**
      - **Vitamin B12**

   c. Electrocardiogram (only if you have had one done within the last two years).

2. ***Financial Documents:***
    a. Completed Weill Cornell Physicians Financial Policy Form.
    b. Insurance information and card (i.e., HMO, Medicare, Medicaid).
    c. If your insurance plan requires an authorization, please be sure to obtain one before arriving to your appointment. If your insurance plan requires a referral, please present the referral at check-in.

CWCC RESEARCH CONSENT:

1. Are you willing to participate in our patient registry? We hope to learn more about how different people respond to weight loss medication. You will receive your usual care with your provider at the CWCC whether or not you participate in this registry. If you check yes, our research team will discuss this with you in more detail.

    □ Yes   □ No

2. Do you consent to give our research team permission to contact you about studies you may be eligible to enroll in?

    □ Yes   □ No

****** It is your responsibility to ensure all the documents are on site prior to or brought with you to the appointment ******

WEIGHT HISTORY

What is the reason for your visit today? ____

Current Weight	Current Height	Highest (non-pregnant) Weight and Date	Pre-Pandemic (Jan 2020) Weight

Recent Blood Pressure Measurement: ______________ Recent Heart Rate Measurement: __________________

Please describe any previous weight loss attempts and mention the highest weight lost and how that was achieved:

____

____

What best describes your weight over the past year? ☐ Gaining ☐ Losing ☐ Stable

If you have had a previous weight loss surgery or procedure, please indicate below:

☐ Gastric Bypass ☐ Sleeve Gastrectomy ☐ Lap Band ☐ Other ☐ None

Pre-Surgery/Procedure Weight and Date: __________ Lowest Weight After Surg/Proc and Date: __________

If you have ever taken a medication for weight loss, please provide additional details below:

____

____

____

Please comment on the most significant challenges that you face in losing weight / maintaining weight loss?

____

____

____

Please comment on any factors motivating you to pursue weight loss at this time:

____

____

DIET HISTORY / EATING HABITS

Describe a typical day with regard to food/beverage content and share frequency of meals dined out/ordered in:

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	

Dietary restrictions/limitations (health, cultural, religious, food allergies/insensitivities): ____________________________

____

If you have ever suffered from an eating disorder, please share more information: ________________________________

____

If you have ever gained weight from taking a medication, please share more information: __________________________

____

Do you feel out of control when eating?	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No.
Do you eat large volumes in a short time (binge)?	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No.
Do you eat late at night?	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No.
Do you wake up from sleep and eat in the middle of the night	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No.
Do you typically require more than one serving to feel full?	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No.
Do you experience cravings:	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No. What types of foods do you crave (sweets, carbs, savory, other): ______________ Typical time(s) of day that cravings occur: ________________________________
Do you drink alcohol?	☐ Yes, daily. ☐ Yes a few times per week. ☐ Yes, less than once/week. ☐ No. Average number of drinks per week: ______________________________________
Do you smoke cigarettes?	☐ Yes ☐ No If yes, how many cigarettes or packs per day? ____________________________________

Please comment on your current activity level (strength training, cardio/aerobic training, step count). If you have a regular routine, please comment on minutes per activity session and number of sessions per week.

____

____

PAST MEDICAL HISTORY. Mark (x) all that apply.

☐ Acid Reflux Disease	☐ Constipation	☐ Heart Disease	☐ Miscarriage	☐ Suicide Attempt
☐ Alcoholism	☐ Diabetes (Type 1)	☐ Hepatitis	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Anemia	☐ Diabetes (Type 2)	☐ High Blood Pressure	☐ Osteoporosis/penia	☐ Tuberculosis
☐ Anorexia	☐ Emphysema	☐ High Cholesterol	☐ PCOS	☐ Foot Ulcers
☐ Arthritis	☐ Epilepsy	☐ HIV Disease	☐ Pacemaker	☐ GI Ulcers
☐ Asthma/Lung Problem	☐ Fatty Liver	☐ Irregular Menstrual Periods	☐ Prediabetes	☐ Other ________ ________ ________ ________ ________ ________ ________ ________
☐ Bleeding Disorders	☐ Gall Bladder Disease	☐ Impaired Fasting Glucose	☐ Prostate Problem	
☐ Bulimia	☐ Glaucoma	☐ Kidney Stone	☐ Psychiatric Care	
☐ Cancer	☐ Goiter	☐ Liver Disease	☐ Sleep Apnea	
☐ Chronic Kidney Disease	☐ Gout	☐ Migraines	☐ Stroke	

1. Other present health problems/dates of diagnosis: ____

____

2. List all surgeries/hospital admissions with date and reason: ____

____

3. List your current medications. Include any vitamins and supplements

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

4. Please list allergies that you have to medications, foods, or other substances: ____________________________

____

5. Some medications can cause weight gain. Do you take medication for any of the following conditions? Note that **not** all medications for these conditions cause weight gain.

☐ Depression	☐ Beta/Alpha Blockers for Blood Pressure
☐ Mood Disorders	☐ Strong Antihistamines for Severe Allergies
☐ Seizures	☐ HIV Infection
☐ Diabetes	☐ OTC Sleep Medicine (i.e., Tylenol PM)
☐ Birth Control	☐ Steroid Hormones for Inflammation, Arthritis
☐ Endometriosis	☐ None of the Above

SLEEP HEALTH QUESTIONS:

Question	Response
1. Do you snore loudly? Louder than talking or loud enough to be heard through closed doors	☐ Yes. ☐ No. ☐ Not sure
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ Yes. ☐ No. ☐ Not sure
3. Has anyone observed you stop breathing during sleep?	☐ Yes. ☐ No. ☐ Not sure
4. Do you have (or are you being treated for) high blood pressure?	☐ Yes. ☐ No. ☐ Not sure
5. Is the circumference of your neck 40cm or greater?	☐ Yes. ☐ No. ☐ Not sure

FAMILY HEALTH HISTORY:

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE OF DEATH
Father				
Mother				
Sibling(s)				
Spouse				
Children				

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DEMOGRAPHICS

Name: ____Date of Birth_________________________

Sex: ___________ Today's Date __________________________

Home Phone #: _________________________Cell Phone #: __________________Work #: ______________________________

Address: ____Apt#: ____________________

City: ____State: _____________________Zip: _____________________

Email: ____

Occupation: _______________________________Employer: ____

Marital Status: __________________Do you have children? _________Age(s) of children: _____________________________

With whom do you live? (Include relatives and/or friends) ____

Primary Care Provider: _______________________________________Physician's phone: ______________________________

Date of last exam: ______________________

Referring Physician: ____Physician's phone: ______________________________

EMERGENCY CONTACT

Name: ____Phone: _____________________________

Relationship:____

PREFERRED PHARMACY

Name: ____Phone: ____________________________

Address: ____

INSURANCE INFORMATION

Name of Primary Insurance Co.: ____

Name of Policy Holder, if other than patient: __________________________________DOB: __________________________

Relationship to patient (circle one): Self, Spouse, Child, Other: ____

Insurance ID #: _______________________________________Group #: ____

Secondary Insurance Co. (if any): ____

Insurance ID #: _______________________________________Group #: ____

Weill Cornell Physicians

Financial Policy

Thank you for choosing Weill Cornell Physicians for your health-care needs.

The following is our payment policy which we require you to read and sign prior to your visit(s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Site Manager to discuss a satisfactory arrangement.

Participating Plans

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier or a claim can be mailed to you.

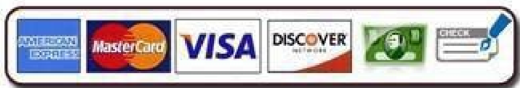
Payment in full is due at the time of service for all non-medically necessary services and/or cosmetic services.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

For your convenience, the following payment methods are accepted:
Cash, personal check, Visa, MasterCard, American Express, Discover



I have read the policy, I understand and agree to it

______________________________ ______________________________
Patient Signature Date

____
Print Name

Weill Cornell Medicine NewYork-Presbyterian

COMPREHENSIVE WEIGHT CONTROL CENTER
MISSED APPOINTMENT & LATE CANCELLATION POLICY

Impact of Missed Appointments

The health of all our patients is very important to us at the Comprehensive Weight Control Center. Missed appointments can not only potentially affect your health outcomes, but whenever you miss an appointment without providing adequate notice, another patient misses an opportunity to receive vital care.

In order for us to provide quality care in a timely manner for all our patients, **a fee of $75.00 may be charged for any missed or late cancellation appointments. This fee must be paid before your next appointment; this fee is not covered by your insurance.**

Definition of a Missed Appointment

A missed appointment is any scheduled appointment in which the patient either:
(1) Does not arrive to their scheduled appointment,
(2) Cancels their appointment with less than 48 hours prior notice, or
(3) Arrives more than 15 minutes late for their appointment and is unable to be accommodated by the practice.

Avoiding Missed Appointments

We understand that situations may arise where you will be unable to keep your appointment. **To cancel or reschedule, please call us at (646) 962-2111 before 48 hours of your scheduled appointment.** (To cancel a *Monday* appointment, please call us by 12:00 PM on *Friday.)*

Our business hours are Monday through Friday from 8:00 AM to 5:00 PM, excluding holidays.

We understand that unexpected delays can happen, but we do need to try to keep all our patient appointments running on time. **Patients who arrive later than 15 minutes after their scheduled appointment time may miss their appointment, and incur the missed appointment fee.**

By signing below, I acknowledge that I understand the contents of the Comprehensive Weight Control Center's Missed Appointment and Late Cancellation Policy. I agree to be full responsible for the fee of $75.00 if I missed my appointment. I will not submit the bill for these services to my insurance carrier.

______________________	______________________	______________________
Patient Name	**Patient Signature**	**Date**

Physician Disclosure of Financial Interest

For patients referred to **Dr.** ______________________

Your provider, referenced above, and/or his/her family members, has a financial interest in (e.g., is employed by, receives consulting fees from, and/or has an equity interest in) Intellihealth Inc., which developed and licenses the Evolve patient portal. The Evolve software and products may be used in the ongoing treatment for your medical condition.

However, your provider does not receive any payments from Intellihealth specifically directed to the use of its products for your care at Weill Cornell Medicine.

You should feel free to ask your provider any questions you may have about these financial interests. If you are not comfortable discussing this with the provider, you may contact the Weill Cornell Medicine Office of Research Integrity at 646-962-8200.

By signing below, you acknowledge: (i) your receipt of this Physician Disclosure of Financial Interest, (ii) that you have been given the opportunity to ask questions, and (iii) that your questions have been answered to your satisfaction.

____

Patient Name

____

Patient Signature

____

Date