Memorial
WEIGHT LOSS & WELLNESS CENTER

Weight Loss & Wellness Center
Patient Responsibilities

Name:_____DOB:_____ Date of service:_____

Provider:_____MRN: _____

The goal of the Memorial Weight Loss & Wellness Center is to restore you to good health and improve quality of life. Your team stresses that you must be responsible for helping to achieve and maintain that quality of life.

_____ (Initial) *****NOTICE OF NO-SHOW/CANCELLATION POLICY*****
I must give at least 24-hour notice if canceling an appointment with the team with a reason for cancellation(s). I understand that I will be inactivated for at least one year if I:
- "No-show" three (3) or more appointments with the bariatric team
- Cancel three (3) or more appointments without proper notification and/or justification

_____ (Initial) **Appointments:** I understand I am responsible for scheduling and keeping appointments for clinic visits with the team members. If I cancel an appointment, I will give 24-hour notice. It is also my responsibility to come to my appointments ON TIME. Failure to do so can result in the need to reschedule the appointment. We respect your time and want to ensure that you and your clinician, as well as other patients attending appointments, have the undivided attention of our team. **I understand that if I bring young children to my visits and they cannot be left unattended in the waiting room, my visits will be rescheduled.**

_____ (Initial) **Health Maintenance:** I understand I have a responsibility to play an active role in my obesity treatment by following nutrition instruction, maintaining recommended physical activity, obtaining laboratory work-up and other tests as determined by the team. I agree to allow Memorial Weight Loss & Wellness Center to communicate with my primary care physician regarding my status/progress with the program.

_____ (Initial) **Weight Loss and Wellness Team:** I understand that I am responsible for treating all members of the team with courtesy and respect. Verbal abuse, profanity, arguing, demeaning comments, aggressive behavior or continued harassment of multiple phone calls in a short period of time is inappropriate behavior. Non-compliance is grounds for dismissal from the program.

_____ (Initial) **Financial:** I understand I am responsible for notifying the insurance specialist of any changes in my healthcare coverage that may affect my care. I understand that I am also responsible for out-of-pocket expenses related to my care. I understand that if I neglect to make payments and/or establish a payment plan, I will be held from continuing with my program.

Weight loss program of interest:
❑ Medical weight loss
❑ Surgical weight loss
❑ Optimization (elective procedure)
❑ Diabetes self-management services
❑ Undecided

Individual SMART Goal: _____

_____

Patient signature: _____ Date: _____