Weight Management Comprehensive Medical History Form

Name: _____ DOB: _____
Parent/Guardian Name (if patient is under 18): _____ DOB: _____
Address: _____
Phone Number: _____ Work Phone: _____
Email: _____
Insurance:
Primary: _____ Member ID: _____
Secondary: _____ Member ID: _____
PCP: _____ Referral source: _____
PCP's Phone Number: _____ PCP's Fax Number: _____

1. Medical & Family History

Current Medical Concerns: _____
Chronic Conditions (check all that apply):
☐ Asthma ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Fatty liver
☐ PCOS ☐ Depression/Anxiety ☐ ADHD ☐ Sleep apnea ☐ Other: _____
Past Surgeries or Hospitalizations:
_____
Current Medications (include OTC, supplements):
_____
Allergies (food, medication, environmental):
_____
Family History (parents, siblings, children):
☐ Obesity ☐ Type 2 Diabetes ☐ Heart Disease ☐ High Cholesterol
☐ High Blood Pressure ☐ Mental Health Disorders ☐ Eating Disorders
☐ Other: _____

2. Growth and Development - PEDIATRIC PATIENTS ONLY

Birth weight: _____ lbs ____ oz Gestational Age at Birth: _____ weeks
Any complications during pregnancy or delivery? ☐ Yes ☐ No
If yes, explain: _____
Developmental Delays? ☐ Yes ☐ No
If yes, describe: _____

3. Nutrition & Eating Habits

Typical daily meals (what and when):
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks (include soda, juice, milk, water, etc.): _____
Portion sizes: ☐ Small ☐ Medium ☐ Large
Picky eater? ☐ Yes ☐ No If yes, details: _____
Who prepares meals at home? _____
How often do you eat meals as a family? ☐ Rarely ☐ 1–2 x/week ☐ 3+x/week
Fast food or restaurant meals: ☐ Never ☐ 1–2x/week ☐ 3+x/week
Late-night eating or snacking after dinner? ☐ Yes ☐ No
Concerns about food or eating behaviors (sneaking, restricting): ☐ Yes ☐ No
If yes, describe: _____

4. Physical Activity & Sedentary Behavior

Current level of physical activity: ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous
Types of activities/exercise you or your child enjoy: _____
Organized sports or physical activities: ☐ Yes ☐ No
If yes, what, and how often? _____
How many days per week do you or your child engage in physical activity of at least 30 minutes?
☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ Daily

Total number of minutes of exercise weekly: _____
Screen time (TV, tablet, phone, video games):
Weekdays: _____ hours/day
Weekends: _____ hours/day
Do you or your child have a TV, computer, tablet in their bedroom? ☐ Yes ☐ No

5. Sleep Assessment

Usual bedtime: _____ PM Wake time: _____ AM
Average total sleep duration per night: _____ hours
Difficulty falling or staying asleep? ☐ Yes ☐ No
Snore loudly or gasp during sleep? ☐ Yes ☐ No
Feel tired during the day? ☐ Yes ☐ No
Share a room or bed with others? ☐ Yes ☐ No
Sleep Quality (scale of 1–10): _____ (1 = very poor, 10 = excellent)

6. Behavioral and Emotional Health

Concerns about:
Mood or emotions ☐ Yes ☐ No
Self-esteem/body image ☐ Yes ☐ No
Bullying/peer relationships ☐ Yes ☐ No
Attention or hyperactivity ☐ Yes ☐ No
If yes to any, please describe: _____
Have you or your child seen a counselor, psychologist, or psychiatrist? ☐ Yes ☐ No
If yes, for what reason? _____

7. Weight Management history

Previous weight management programs: _____
Previous weight management medications/surgeries: _____
What worked? _____
What didn't work? _____

8. Goals and Readiness

What are your main concerns or goals for you or your child's health/weight?
_____

How ready do you feel you or your child is to make changes?
☐ Not ready ☐ Somewhat ready ☐ Very ready ☐ Already started

What barriers do you anticipate (time, cost, family habits, etc.)?
_____

CONSENT FOR USE OF ANTI-OBESITY MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT PEACOCK PEDIATRICS WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND DR. FORD DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered "controlled medications." By law, controlled medications can only be prescribed from one facility at a time; therefore, I agree that only Peacock Pediatrics will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Peacock Pediatrics and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at Peacock Pediatrics of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by Peacock Pediatrics. I understand that taking medications in any way other than directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at Peacock Pediatrics are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at Peacock Pediatrics.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after I have active weight loss.

Patient (Printed): _____ Date of Birth: _____
Parent/Guardian Name (Printed, if younger than 18): _____
Signature of Patient/Parent/Guardian: _____
Date: _____

Weight Management Group Visits Consent

Our team will form groups of 5-7 patients with similar backgrounds to be seen as a group. These visits will take place on Microsoft Teams, and Dr. Ford will have individual time with each patient. These visits will be billed as follow-up visits, and all applicable co-pays will apply.

I understand that the group visits are designed to provide education, support, and guidance for weight management through discussions, activities, and shared experiences within a group setting.

Benefits of Participation: Participating in group visits can offer benefits such as increased motivation, shared learning, peer support, and access to additional resources for managing weight.

Nature of Group Visits: The group visits will involve discussions on topics related to nutrition, physical activity, behavioral strategies, and emotional wellness aimed at achieving and maintaining a healthy weight.

Confidentiality: I understand that information shared within the group will be kept confidential within the bounds of group participation and will not be disclosed outside of the group without my consent.

Voluntary Participation: My participation in the group visits is voluntary, and I understand that I can withdraw from the group at any time without penalty or affecting my medical care.

Risk and Discomfort: I understand that while participating in group discussions, I may experience emotional or personal discomfort. The facilitators will work to maintain a supportive and respectful environment.

Use of Information: I agree that information gathered during the group visits, including my participation and progress, may be used for research or educational purposes, but my identity will be kept confidential.

Responsibilities: I understand that it is my responsibility to actively participate in group visits, follow the guidelines provided, and inform the facilitators of any concerns or questions I may have.

Emergency Contact: I will provide emergency contact information to the group facilitators in case of any medical or personal emergencies during the group visits.

Agreement: I have read and understand the nature and purpose of the group visits for weight management. By signing below, I agree to participate in these group visits voluntarily.

Patient (Printed): _____ Date of Birth: _____
Parent/Guardian Name (Printed, if younger than 18): _____
Signature of Patient/Parent/Guardian: _____
Date: _____

Weight Management Program Financial Policy

Thank you for choosing Peacock Pediatrics. We are committed to providing excellent care and transparent communication. To help avoid confusion, please review and sign our financial policy regarding insurance billing, deductibles, coinsurance, and patient responsibilities. We participate with many insurance plans and will bill them directly as a courtesy to you.

It is your responsibility to:

- Verify your insurance benefits before starting the program.
- Provide accurate and current insurance information before each visit.
- Be aware of your insurance plan benefits, including deductibles, co-pays, and coinsurance.
- Notify us immediately of any changes to your insurance.

Copays, Deductibles, and Coinsurance

- Copays are due at the time of service.
- If your plan has a deductible, you are responsible for paying the full allowed amount until it is met.
- After your deductible is met, you may still owe coinsurance- a percentage of the visit or treatment cost.
- We may collect an estimated portion of this cost at the time of your appointment.

Patient Responsibility

- You are responsible for any charges not covered by insurance, including:
- Services not covered under your plan.
- Denials due to lack of prior authorization or referral
- Medications not on your plan's formulary
- It is your responsibility to understand your coverage before services are rendered.
- Balances are due upon receipt of your statement. If your account becomes past due, future visits may be postponed until payment is made.

Billing and Payments

- We accept cash, checks, and major credit/debit cards.
- You may also pay via our patient portal.
- Returned checks are subject to a $25 fee.
- Accounts referred to collections result in discharge from Peacock Pediatrics.

No-Show & Late Cancellation Policy

- To best serve all our patients:
- Please cancel or reschedule at least 24 hours in advance.
- Missed appointments or same-day cancellations may be charged a fee of $25.

Questions?

- If you have any questions about your insurance coverage or a bill you received, please call our billing department at 816-422-2300.

Acknowledgement and Agreement

I have read, understand, and agree to the above Financial Policy. I understand that I am financially responsible for all charges not covered by my insurance.

Patient (Printed): _____ Date of Birth: _____
Parent/Guardian Name (Printed, if younger than 18): _____
Signature of Patient/Parent/Guardian: _____ Date: _____

Insurance Verification Notice for Weight Management & Obesity Treatment

Dear Parent/Guardian/Patient,

As part of our commitment to providing comprehensive care, Peacock Pediatrics offers weight management services that may include medical evaluation, nutritional counseling, behavioral health support, prescription medications, and, when appropriate, referrals for bariatric surgery.

Please be aware: **Insurance coverage for obesity and weight management services-including medications and surgery-can vary significantly depending on your individual health plan.** Some services may require prior authorization or may not be covered at all under certain plans.

What You Need to Do:

To avoid unexpected costs, it is your responsibility to contact your insurance provider before your visit or treatment begins and ask the following questions:

1. Are weight management and obesity-related services covered under my plan?
2. Does my plan cover nutritional counseling or behavioral health support for weight loss?
3. Are prescription weight loss medications covered? Are there preferred or excluded medications?
4. Is bariatric surgery a covered benefit? If so, what is the eligibility criteria?
5. Do I need a referral or prior authorization for any of these services?
6. What are benefits, exclusions, or limitations regarding telehealth services?

We will gladly provide any documentation needed to support your insurance inquiries.

If you have questions about this process or need help identifying what to ask your insurance company, please let us know.

By signing below, you acknowledge that you have received and understand this notice.

Patient (Printed): _____ Date of Birth: _____
Parent/Guardian Name (Printed, if younger than 18): _____
Signature of Patient/Parent/Guardian: _____
Date: _____

Thank you for being a valued patient of Peacock Pediatrics.

Goals:

Physical activity:

Short Term:

_____

_____

Long Term:

_____

_____

Nutrition:

Short Term:

_____

_____

Long Term:

_____

_____

Behavioral:

Short Term:

_____

_____

Long Term:

_____

_____