



# Medical Bariatrics of Lexington

2716 Old Rosebud Rd, Suite. 160  
Lexington, Kentucky 40509  
Phone: (859) 263-SLIM (7546) Fax: (859) 263-2388  
Dr. Julie Swindler Medical Director

Thank you for choosing Medical Bariatrics of Lexington to help you with your weight management needs. We really look forward to meeting you.

Our address is **2716 Old Rosebud Rd, Suite 160, Lexington, KY, 40509** off of Sir Barton Way in the **Hamburg** section of Lexington. Please visit our website at: **[www.lexingtonkyweightloss.com](http://www.lexingtonkyweightloss.com)** for driving directions, great information on what you can expect, estimated costs, and answers to the most commonly asked questions.

Here are a few things you should know and have ready for this first appointment.

- 1) **Be prepared to have your labs drawn** the day of your appointment. If you have a **copy of blood lab results done within the last three months**, please bring a copy to the office for your first appointment for evaluation and/or comparison. Do not eat or drink anything other than water or black coffee 8 hours prior to the appointment so we can draw **“fasting”** labwork. Non fasting labs may need to be repeated if significantly abnormal. If you would like fasting morning labs done prior to your appointment day or prior to an afternoon appointment, please notify us so we can arrange for you a time to get them drawn. In either case, **please drink a minimum of 4 glasses of water prior to your appointment so that you are fully hydrated, which will make it easier to obtain your blood.**
- 2) **Please do not wear any type of lotion or oil** to this appointment in preparation for your **EKG**. If you had one done in the past 3 months, please **bring a copy of it**, but remember to still not wear the lotion in case it needs to be repeated.
- 3) Bring a **list of all medications and dosages with you**.
- 4) Please **fill out the enclosed Patient Medical History form, Informed Consent form, Your Rights form, and Rules for Use of Weight Loss Control Medications form** and bring with you to the appointment.
- 5) **Do not wear body suits, spanx, girdles or clothing that constricts tightly**. These clothing articles can affect the accuracy of your measurements and/or weighing process.
- 6) Remember that **payment is required day of service**. While we strive to be accurate in preliminary cost information, variances can occur as a result of your visit.(See website for details.)

Patients paying for services using a credit/debit card carrying a name other than their own (person or business) will be required to have the person the card belongs to come into MBL to complete a Payment Authorization form. At that time, the Drivers License (or other acceptable photo I.D.) of the authorizing Person will be scanned for retention.

- 7) Due to having blood pressure taken and blood drawn, please wear **short sleeves and a loose top**.
- 8) **Some patients like to have before and after pictures taken**. These are optional, but we do provide them without charge if desired. Thus, be prepared for pictures if desired.

**Please allow approximately two and one half hours for this first appointment**. Because of the length of time you will be here, please do not bring small children to this appointment.

We look forward to meeting you and helping you to achieve your weight management goals.

Sincerely,

Julie Swindler MD, Allen Rader MD, & the Staff at Medical Bariatrics of Lexington



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## Directions

### From the East (Winchester):

I-64 W to exit #81 Richmond/Knoxville onto I-75 S. Go 2.9 miles,  
Take exit #108 Man O'War Blvd.  
Go Southwest onto Man O'War for 0.6 miles, then  
Turn right onto Sir Barton Way and go 1 mile, then  
Turn right onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4th white building  
(right across from the store "My Favorite Things")

### From the North (Georgetown):

I-75 S towards Richmond/Knoxville  
Take exit #108 Man O'War Blvd.  
Go Southwest onto Man O'War for 0.6 miles, then  
Turn right onto Sir Barton Way and go 1 mile, then  
Turn right onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4<sup>th</sup> white building  
(right across from the store "My Favorite Things")

### From the West (Versailles):

Take US-60 E to New Circle Rd (Us-60-BYP North)  
towards I-75/KY-4N/I-64  
Go 8.2 miles, then take exit #13 (Winchester Rd./I-64)  
Bear left onto Winchester Rd. (US-60) and go 1.4 miles  
Turn right onto Sir Barton Way and go about 0.3 miles  
Turn left onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4<sup>th</sup> white building (right across from the store "My Favorite Things")

### From the West (Frankfort):

Take I-64 E to the I-64/75 Split. Continue on I-75 S for 2.5 miles.  
Go .3 miles, then take Exit #108 Man O'War Blvd.  
Go Southwest onto Man O'War for 0.6 miles, then  
Turn right onto Sir Barton Way and go 1 mile, then  
Turn right onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4<sup>th</sup> white building (right across from the store "My Favorite Things")

### From the Southwest (Nicholasville):

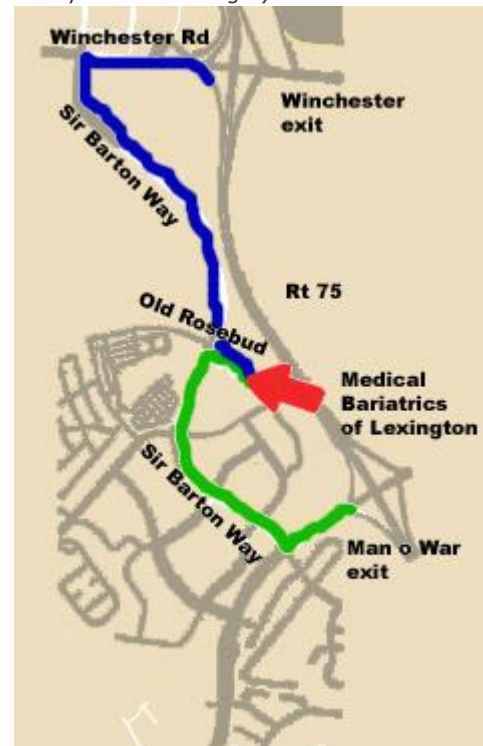
Take Nicholasville Road (US-27) North to New Circle Road (KY 4 E)  
Turn onto New Circle Road heading East and go 4.2 miles  
Take exit #15 Lexington/Richmond onto Richmond Rd (US 25 S)  
Turn right onto Richmond Rd and go 1.3 miles  
Turn left onto Man O'War Blvd (KY-1425 E) and go 2.3 miles  
Turn left onto Sir Barton Way and go 1 mile, then  
Turn right onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4<sup>th</sup> white building (right across from the store "My Favorite Things")

### From the South (Richmond):

Take I-75 N to exit #108 Man O'War blvd West  
Turn left onto Man O'War Blvd (KY 1425 W) and go 0.5 miles  
Turn Right onto Sir Barton Way and go 1 mile then,  
Turn right onto Old Rosebud Rd.  
You will see Hamburg Business Center buildings to your right  
MBL's office in on the 1st floor of the 4<sup>th</sup> white building (right across from the store "My Favorite Things")



Note: 2716 is on the top of the building along with a Bariatrics sign that has "MBL Medical"



Call: (859) 263-SLIM(7546) for questions

MEDICAL BARIATRICS OF LEXINGTON

New Patient History (Please PRINT All information clearly) Date: \_\_\_/\_\_\_/\_\_\_

Name Preferred Nickname: Social Security#:
Date of Birth Age Are you on Medicare? Spouse
Occupation: Employer name and Phone #
Primary Physician PCP Phone #

Preferred Pharmacy name: Location: Pharmacy phone:

Childproof medication bottle needed? Yes No If no, sign here:

Your address City/State Zip

Home phone: Work: Cell:

Please indicate which phone number you would like for us to use as your primary number.

Email:

- Your lifetime non-pregnant max weight: lbs
Your goal weight: lbs
Age when you were last at your goal weight:
Overall goals: What do you hope to accomplish by being here?
Have you ever had bulimia?
Binge eating disorder?
Anorexia?
How many alcoholic beverages in a week?
Do you smoke? how much/day?
If you smoke: Since what age?
If you used to smoke, when did you quit?
What was your weight:
1 year ago, 5 yrs ago 10yrs ago
Are you: Male or Female
LADIES: Are you pregnant? Breastfeeding?
Do you have abnormal periods?
Date of Last Period?
Are you menopausal or perimenopausal?

Table with 2 columns: Current meds and doses, Taking it for? (1-10)

Over the counter meds/vitamins/herbals (1-10)

What serious illnesses have you had in the past?

What surgeries have you had in the past?

What medications are you allergic to?

What weight loss meds or programs have you tried in the past?

Any problems with them? What worked?

Why do you think they haven't worked?

Why do you think you struggle with your weight?

What's a typical day of food like: Breakfast: Lunch:

Dinner: Snacks:

WHO in your FAMILY have had the following?(mom,dad, siblings, aunts/uncles, cousins, grandparents)

- Heart Disease/Heart Attack/ Congestive Heart Failure
Cancer: (list type) Hypothyroidism
High Cholesterol High Blood Pressure
Sudden death < age 40 from medical condition Stroke
Diabetes or "borderline diabetes"
Mental illness (depression, bipolar, etc.)
Who in family struggles with weight?
Other family medical conditions

(Over)

# MEDICAL BARIATRICS OF LEXINGTON

Name: \_\_\_\_\_

Please **circle** the **medical conditions** that **YOU** have been diagnosed with in the past or currently.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li><input type="radio"/> Past or current drug or alcohol problems</li> <li><input type="radio"/> Depression or anxiety</li> <li><input type="radio"/> Diabetes: Type 1 (juvenile) or 2 (adult)?</li> <li><input type="radio"/> Gestational Diabetes</li> <li><input type="radio"/> Insulin Resistance/Prediabetes/Borderline Diabetes/Dysmetabolic Syndrome</li> <li><input type="radio"/> Polycystic Ovarian Syndrome</li> <li><input type="radio"/> Heart Burn</li> <li><input type="radio"/> Glaucoma (Open or Narrow Angle?)</li> <li><input type="radio"/> High Cholesterol</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> High Blood Pressure</li> <li><input type="radio"/> Heart Disease/Heart Attack/Heart Failure</li> <li><input type="radio"/> Arrhythmia</li> <li><input type="radio"/> Heart Valve Problems/Heart Murmurs</li> <li><input type="radio"/> Do you have a pacemaker: yes or no</li> <li><input type="radio"/> Do you have a defibrillator: yes or no</li> <li><input type="radio"/> History of passing out (syncope)</li> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> Other Lung diseases (Type: _____)</li> <li><input type="radio"/> ADHD (Attention deficit disorder)</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Bipolarism or other psychiatric conditions? _____</li> <li><input type="radio"/> Kidney Diseases (Type: _____)</li> <li><input type="radio"/> Liver Diseases (Type: _____)</li> <li><input type="radio"/> Obstructive sleep apnea (use a CPAP?)</li> <li><input type="radio"/> Insomnia/ other sleep disorders</li> <li><input type="radio"/> Thyroid Disorders (Low or High or Other: _____)</li> <li><input type="radio"/> Other Chronic Medical Conditions: _____</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\*\*\*\*\*

Please circle if you have been having any of the following **symptoms**

- |                           |                          |                        |                                 |
|---------------------------|--------------------------|------------------------|---------------------------------|
| 1) Weakness               | 8) Thick tongue          | 15) Swollen feet       | 22) Swelling of face & eyelids  |
| 2) Dry, Coarse skin       | 9) Coarse hair           | 16) Hoarseness         | 23) Excessive or painful menses |
| 3) Tired/fatigue          | 10) Pale skin            | 17) Loss of appetite   | 24) Emotional Instability       |
| 4) Slow speech            | 11) Constipation         | 18) Poor memory        | 25) Depression                  |
| 5) Slow movement          | 12) Gain in weight       | 19) Nervousness        | 26) Headaches                   |
| 6) Coldness and cold skin | 13) Loss of hair         | 20) Heart palpitations |                                 |
| 7) Diminished sweating    | 14) Difficulty breathing | 21) Brittle nails      |                                 |

**Please check here if none of the above 26 symptoms apply to you**

\*\*\*\*\*

**Exercise frequency?**

**What is the intensity?**

**For how long?**

- |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> 1-2x/week</li> <li><input type="checkbox"/> 3-5x/week</li> <li><input type="checkbox"/> Daily</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Light (brisk walking, golfing, doubles tennis)</li> <li><input type="checkbox"/> Moderate (biking, low impact aerobics)</li> <li><input type="checkbox"/> Moderately hard (running, aerobics, hockey)</li> <li><input type="checkbox"/> Very hard (Sprinting, speed swimming)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Under 10 minutes</li> <li><input type="checkbox"/> 10-20 minutes</li> <li><input type="checkbox"/> 20-30 minutes</li> <li><input type="checkbox"/> over 30 minutes</li> </ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Do you have any physical restrictions to exercise? (what are they) \_\_\_\_\_

\*\*\*\*\*

- |                                                                        |        |
|------------------------------------------------------------------------|--------|
| 1. Do you make yourself sick because you feel uncomfortably full?      | Y or N |
| 2. Do you worry you have lost control over how much you eat?           | Y or N |
| 3. Have you recently lost more than 15 pounds in a three-month period? | Y or N |
| 4. Do you believe yourself to be fat when others say you are too thin? | Y or N |
| 5. Would you say that food dominates your life?                        | Y or N |

\*\*\*\*\*

**Lifestyle challenges:** Which of the following seem to sabotage your weight loss efforts:

1. Lack of time for planning & self	2. Eating late/waking up eating	3. Eating too fast
4. Comfort/stress eating	5. Liquid calories such as alcohol	6. Always hungry
7. Enjoyment of food	8. Specific food cravings like carbohydrates	9. Boredom eating
10. Social Events	11. Mindless eating/Habit	12. Other:

\*\*\*\*\*

**HOW DID YOU HEAR ABOUT THE CLINIC?**

**Radio** (Which station?) \_\_\_\_\_ **Magazine** (Which one?) \_\_\_\_\_

**TV Station** (Which one?) \_\_\_\_\_ **Commercial** --or-- **Interview**

**My doctor's office referred me to you. Dr or PA name:** \_\_\_\_\_

**Yellow Pages** (Which book?) \_\_\_\_\_ **Newspaper Ad** (Which section?) \_\_\_\_\_

**Internet** Google Yahoo I typed in your website Other? \_\_\_\_\_

**Mailer to the house** \_\_\_\_\_ **Bulletin** (Which one?) \_\_\_\_\_

**My family member, friend or co-worker** who is currently a patient here inspired me to start. *Please share who this was so we can say thank you to them. Their name please:* \_\_\_\_\_

**Other** \_\_\_\_\_



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Dr. Julie Swindler,

Medical Director

Name: \_\_\_\_\_

(Please print)

## Informed Consent for Treatment

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the use of medicines, length of use of medicine, or medication dosings may be used in an "off label" manner. This means the doctor may be using the medicines safely in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine. Please note that the use of medications for weight loss is optional, and no weight loss treatment (including use of medications) guarantees successful weight loss.

## Your Role

1. Provide **honest** and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.
2. Devote the **time and effort** necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal physician if necessary.
4. Make and keep **follow-up appointments** so that we can help you the best, allowing necessary blood tests as needed. Patients more than 15 minutes late for an appointment may be rescheduled to another day.
5. Advise the clinic staff and dr. of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a primary physician before beginning this program.

## Possible Side Effects

1. **Reduced weight.** By reducing your caloric intake, you may see a variety of **temporary and reversible** side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects. This will be closely monitored as safety is our number one priority.
2. **Reduced potassium levels or other electrolyte abnormalities.** We monitor electrolyte levels and correct them if they become too low. If they were not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.
3. **Gallstones.** Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.
4. **Pancreatitis.** Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.
6. **Sudden death.** Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.
7. **Risk of weight regain.** Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued. We will provide you with a maintain plan and plan to help prevent weight regain.

**PLEASE READ AND SIGN BACK PAGE**

Initial here: \_\_\_\_\_



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Medical Director

Name: \_\_\_\_\_  
(Please print)

## Your Rights and Confidentiality

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

Please note that our Physicians do not take calls outside MBL's office hours. If you feel you are experiencing a medical emergency **at any time**, go to the nearest emergency room immediately for treatment.

(HIPAA)

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION

**Uses and Disclosures of Information that We May Make Without Written Authorization:** For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody.

**Uses and Disclosures of Information That We May Make Unless You Object:** We may use and disclose protected health information in the following instances without your written authorization unless you object.

If you object, please notify the Privacy Contact identified at the end of this document.

**Persons Involved in Your Health Care:** Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

**Notification:** Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Person(s) Authorized to Receive Information \_\_\_\_\_

Physician Office(s) Authorized to Receive Medical Information \_\_\_\_\_

**Your Right Concerning Your Protected Health Information:** You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

**Entities to Whom This Notice Applies:** This notice applies to the Medical Bariatrics America, their associated clinics, the physicians, employees, and volunteers who work there.

**Privacy Officer Contact:** If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Active Medical Director at Address: 2716 Old Rosebud Rd. Ste. 160, Lexington, KY 40509 (859) 263-7546

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction. I understand that payment is due at time of service or and may include charges incurred for No Show appointments. Checks will not be held for deposit at a later date. I also understand that if payment is not made, I agree to pay any fees incurred while collecting payment along with a \$25 fee for any returned check. Guarantor (myself) understands that I will be responsible for the balance and up to an additional 40% of the balance if the account is placed for collections with a third party agency. I understand that MBL does not file medical insurance claims and cannot guarantee that insurance will reimburse for services provided. I understand MBL physicians have additionally opted out of Medicare payment benefits, thus Medicare may not reimburse you for services provided here. You are responsible for notifying us if you receive Medicare for further required information. Please sign here to confirm your responsibility.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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Name: \_\_\_\_\_  
(Please print)

## FINANCIAL OPTIONS

### **Payment is due at time of service.**

MBL accepts cash, checks, Visa, Mastercard, Discover, or Care Credit as payment.

#### **Checks**

Checks will not be held for deposit at a later date than the day of service.

Checks are processed through ECHO (an Automated Clearing House), which requires use of your Driver's License for verification.

There will be a \$25 fee for any returned checks.

Returned checks not paid in a timely manner are processed through the Fayette County Attorney's office, which results in an additional \$50 charge to the patient by them.

#### **Credit/Debit Card (including HSA/Flex account cards)**

If paying by credit/debit card, the card must bear the patient's name (photo id to be presented).

Payments to be made using another person's credit/debit card must have written authorization on file in our office no later than the time of the first visit. Photo id must also be presented for the person authorizing the charges.

#### **CareCredit**

CareCredit is a credit card exclusively used for healthcare services. With CareCredit, you can get a No Interest plan if paid in full within 6, 12, 18, or 24 months on services paid for with your CareCredit card. Interest will be charged to your account from the purchase date if the promotional balance, including optional charges, is not paid in full within 6, 12, 18, or 24 months or if you make a late payment. Minimum monthly payments required. The length of time you have to pay depends on the promotional payment plan that you choose when you use the card.

If interested in establishing a CareCredit account, please notify us at least 48 hours in advance of your scheduled appointment so we can explain how you can sign up for the account. Applications and acceptance for CareCredit should be completed prior to your appointment time.

MBL does not delay processing of office visit charges pending CareCredit approval.

**Missed appointments, or appointments not cancelled 24 hrs in advance** may be charged at a \$65 fee, due at the next visit or billable if treatment is discontinued.

If payment is not made for any reason, you agree to pay any fees incurred while collecting payment, including up to an additional 40% of the balance if the account is placed for collections with a third party agency.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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## RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.

1. Many weight loss medications are considered "controlled medications." By law, a controlled medication can only be received from one facility at the same time. I agree that only Medical Bariatrics will prescribe scheduled weight loss medications for me. I agree that it is my responsibility to inform my doctor and any other doctors from whom I receive treatment of this contract, and that it is my responsibility to inform any and all doctors from whom I receive treatment if I am prescribed and/or taking any scheduled medications. Medical Bariatrics may also notify my other doctors of the terms of this contract.
2. I understand that the use of weight loss medications is contraindicated with certain medical histories, or other medication use. I agree that I will be completely honest in disclosing this information & will notify my MBL physician of changes to my medical history or new medication usage. I understand that failure to do so can be dangerous to my health.
3. I agree to take the medication only as prescribed by Medical Bariatrics. I understand that taking medications in any way other than prescribed may be dangerous to my health.
4. I agree to arrange for prescription refills for scheduled medications from Medical Bariatrics only during regular clinic hours. I understand that controlled medications are not refilled in advance to time of refill. Medications are typically dispensed only in one month increments and only via physician approval during physician appointment with appropriate vital signs. I understand that missing my appointment may mean being out of the medications for a small time period as controlled medications are not refilled via phone. I understand that Medical Bariatrics is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.
3. I understand that medication prescriptions can be filled typically at MBL or another pharmacy of my choice. If I use a pharmacy other than MBL, I agree to use only one pharmacy to fill any weight loss scheduled prescriptions and I give my permission for Medical Bariatrics to notify area pharmacies of the terms of this agreement.
5. My signature placed on this contract indicates that I fully understand each statement and have had the opportunity to ask any questions pertaining to this.

Patient name (print) \_\_\_\_\_ Date \_\_\_\_\_

Patient signature \_\_\_\_\_

Witness signature \_\_\_\_\_ Witness name (print) \_\_\_\_\_