Beaufort Memorial

Weight Loss Contract
Dr. Pellegrino's Weight Loss Program

Participant Name: _____ Date of Birth: _____

Program Overview

Dr. Pellegrino's Weight Loss Program is a **clinically supervised 6-month Intensive Behavioral Therapy (IBT) program** that focuses on nutrition, exercise, behavior modifications, and sometimes medications. The program requires a visit every 1-4 weeks with a certified dietitian depending on individual needs and progress. After 6 months, Medicare requires at least a 6.6-pound weight loss to remain in the program. Commercial insurances vary in requirements.

Goals and Commitments
I, _____, agree to participate in Dr. Pellegrino's Weight Loss Program with the goal of improving my overall health and achieving sustainable weight loss. I commit to adhering to the following guidelines:

1. **Follow the prescribed nutrition plan** provided by Dr. Pellegrino and/or the program's nutritionist.
2. **Engage in the recommended exercise regimen** as outlined in my individualized plan.
3. **Attend scheduled appointments** with Dr. Pellegrino and Nutritionist
4. **Follow medical and professional guidance** regarding supplements, medications, or other health interventions.

Program Expectations
Dr. Pellegrino's Weight Loss Program is committed to providing participants with:

- Personalized guidance tailored to individual health needs.
- Regular check-ins and progress assessments.
- Support from medical professionals, nutritionists.
- Education on healthy eating, physical activity, and lifestyle changes.

Eligibility and Acknowledgment of Risks and Responsibilities
I understand that:

- Participation in this program is subject to medical evaluation, and **not all who apply are eligible**. The screening process takes 7-14 days for review.
- I must complete a medical eligibility screen, which includes providing insurance information, BMI, and details of any health conditions affected by obesity.
- Weight loss results vary by individual and are not guaranteed.
- I am responsible for following the program guidelines and making informed decisions about my health.
- Any medical conditions or concerns should be discussed with Dr. Pellegrino or my primary healthcare provider.
- Failure to comply with the program guidelines may affect my progress and success.

- I am responsible for any co-pays, deductibles, or denials from my insurance provider, as well as costs for laboratory tests, imaging, referrals, medications, supplements, and vitamins. **Participation in this program is elective, it is essential to adhere to financial obligations. All account balances must be kept up to date, and failure to do so may result in dismissal from the program.**
- Dr. Pellegrino will only be treating me for weight loss-related concerns during these visits and will not provide primary care or other medical services.
- Our office will initiate **one initial prior authorization** for medication coverage if requested.
- If my initial prior authorization for medication coverage is denied and an appeal is suggested, I will be responsible for initiating the appeal process.
- **Any subsequent authorizations may require an office visit to complete.**

Agreement and Signatures
By signing below, I acknowledge that I have read and understood the terms of this contract. I agree to participate in Dr. Pellegrino's Weight Loss Program to the best of my ability and commit to making healthy lifestyle choices. Failure to comply with program guidelines may result in disciplinary action, up to and including dismissal from the program.

Participant Signature: _____
Date: _____

****This section to be completed by office staff****

Program Duration: From _____ to _____

Initial appointment with Dr. Pellegrino date: _____

Initial appointment with Nutritionist date: _____

Dr. Pellegrino/Program Representative Signature: _____
Date: _____

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Clinically Supervised Weight Loss Program Questionnaire

Medical Eligibility Screening

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Female ☐ Male
- **Address:** _____
- **Email:** _____
- **Phone:** _____
- **Race/Ethnicity:** ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: _____
- **How did you hear about our program?**
  ☐ Newspaper ☐ Brochure ☐ Friend ☐ Physician ☐ Other: _____

Insurance Information

1. **Primary Insurance:** _____
   - State: ____
   - Policyholder Name: _____
   - Policyholder Date of Birth: _____
   - Policy Number: _____
   - Group Number: _____

2. **Secondary Insurance:** _____
   - State: ____
   - Policyholder Name: _____
   - Policyholder Date of Birth: _____
   - Policy Number: _____
   - Group Number: _____

Physician Information

- **Primary Care Physician:** _____
- **Practice Name:** _____
- **Office Address:** _____
- **Referring Physician (if different):** _____
- **Specialty:** _____

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Weight and Health History

- Current Weight: _____ lbs
- BMI: _____
- Height: _____ in
- Number of Years Overweight: _____
- Highest Adult Weight: _____ lbs (When? _____)
- Lowest Adult Weight: _____ lbs (When? _____)
- Most Weight Lost: _____ lbs (When? _____)
- Method Used for Weight Loss: _____
- Do you currently exercise? ☐ No ☐ Yes
    - If yes, describe your routine: _____

Specialist Treatment

Do you regularly seek treatment from a physician or other provider in any of these areas? (Check all that apply.)

□ Cardiologist □ Chiropractor □ Endoscopic □ Gastrointestinal
□ General Surgery □ Hematologist □ Infectious Disease □ Neurologist
□ Orthopedic □ Pain Management □ Physical Therapist □ Psychiatrist
□ Pulmonologist

Medical History: *Have you ever had:*

Condition	No	Yes	Condition	No	Yes
Cancer	☐	☐	Reflux	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Heart Disease	☐	☐	Sleep Apnea	☐	☐
Hepatitis	☐	☐	Stroke	☐	☐
High Cholesterol	☐	☐	Transfusions	☐	☐
Hypertension	☐	☐	Ulcers	☐	☐
Lung Disease	☐	☐			

- **If yes, type of cancer:** _____
- **Other diagnoses:** _____

Surgical History

- Have you had bariatric surgery? ☐ No ☐ Yes (Year & Facility: _____)
- Other Surgeries: _____

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Medications & Allergies

List all current medications and supplements:

Medication/Supplement	Dosage & Frequency	Reason

List any allergies (medications/food/environmental):

Allergen	Reaction

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Lifestyle & Behavioral Factors

- Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed ☐ Other: _____
- Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
- Do you use tobacco? ☐ No ☐ Yes (How often? _____)
- Do you consume alcohol? ☐ No ☐ Yes (How often? _____)
- Do you use recreational drugs? ☐ No ☐ Yes
- Do you exercise regularly? ☐ No ☐ Yes
  - If yes, describe your routine: _____
- Do you have a family history of medullary thyroid carcinoma ☐ No ☐ Yes
  - If yes list who:_____
- Tobacco use: ☐ No ☐ Yes (How often? _____)
- Alcohol use: ☐ No ☐ Yes (How often? _____)
- Illegal drug use: ☐ No ☐ Yes

Healthy Weight Obstacles

To help us plan the best diet for you, please answer the following questions.

Do any of the following environmental issues listed below affect your weight? If so, please explain.

1. Occupation-related eating issues: □ No □ Yes _____
2. Travel: □ No □ Yes _____
3. Household issues (family/obligations/schedule) □ No □Yes _____
4. Shopping/Cooking/Etc.: □ No □ Yes_____
   Who does the food shopping? _____
5. Meals eaten away from home (frequency/location): □ No □ Yes _____
6. Sleep □ No □Yes _____
7. Financial issues □ No □ Yes _____

Do any of the following eating behaviors listed below affect your weight? If so, please explain.

Night Eating Disorder (Eating extremely late at night or waking up in the middle of the night to eat.)

- Current Problem □ No □ Yes _____
- Past Problem □ No □ Yes _____

Emotional Eating

- Current Problem □ No □ Yes _____
- Past Problem □ No □ Yes _____

Frequent Cravings

- Current Problem □ No □ Yes _____
- Past Problem □ No □ Yes _____

Lack of awareness of hunger

- Current Problem □ No □ Yes _____
- Past Problem □ No □ Yes _____

Lack of awareness of fullness

- Current Problem □ No □ Yes _____
- Past Problem □ No □ Yes _____

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Binge Eating

The following questions ask about your eating problems and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

A. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? : □ No □ Yes
   a. ***NOTE: If you answered no to the above question, you may continue to the next page. The questions below do not apply to you.***

B. Do you feel distressed about your episodes of excessive overeating? : □ No □ Yes

Within the past 3 months ...

	Never or Rarely	Sometimes	Often	Always
During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

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Please answer the questions below to the best of your ability: Attach additional sheets if needed.

1. Do you have any food allergies? □ No □ Yes If yes, what are they?_

2. Do you have any food intolerances? □No □ Yes
   If yes, what are they? _____

3. What would you like to achieve from visiting with the dietitian? _____

4. Do you see any barriers to achieving this goal? □No □ Yes
   If yes, what are they? _____

6. How often do you eat fast food? _____Where? _____
7. What do you typically eat when you order fast food? _____
8. How often do you eat at restaurants? _____
9. What do you typically eat when you Order from a restaurant? _____
10. How often do you eat fried foods? _____
11. What fried foods do you typically eat? _____
12. How often do you eat sweets? _____
13. What sweets do you typically eat? _____

14. Check the box if you use: □ Butter □ Margarine □ Salad Dressing □ Oil □ Mayonnaise

    □ Ketchup □ Marinades □ Sauces □ Gravy

15. Check the box if you drink: □Regular Soda □ Diet Soda □ Water □ Juice □ Juice Drink
    □ Iced Tea □ Coffee □ Tea □ Energy Drinks □ Milk □ Other: _____

16. Do you consume alcoholic beverages? □ No □ Yes
    If yes, what type? _____
    If yes, how often? _____

17. What types of food do you crave? _____
18. Do you eat fruits and vegetables daily? □ No □ Yes
19. What types of fruits and vegetables do you eat? _____
20. Check all that you eat: □ Meat □ Poultry □ Beans □ Tofu □ Nuts □ Eggs
21. Place a check in the box if you eat daily and what type:

Cheese □	Regular full fat □	2% reduced fat □	1% low fat □	0%skim/fat-free □
Yogurt □	Regular full fat □	2% reduced fat □	1% low fat □	0%skim/fat-free □
Milk □	Regular full fat □	2% reduced fat □	1% low fat □	0%skim/fat-free □

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Please add any additional information you would like us to know below.