KOTA METABOLIC INSTITUTE
Obesity, Metabolism & Nutrition

Premier Physicians
TREATMENT BEYOND SYMPTOMS

# IMPORTANT INFORMATION

We would appreciate if you would confirm your contact, billing and insurance information.

*We also need:*

- A copy of your Driver License
- A copy of your insurance card (Patient is responsible in providing office with current insurance throughout the year in a timely manner).
- Co-payment is due at the time of visit, including copay for GTT lab visit and other testing appointments.
- High deductible plan insurance is subject to self-pay.
- A $25 fee will be charged for No-Show and/or cancellations with less than 24-hour notice

**It is the Patients responsibility to know your insurance coverage and guidelines. We cannot guaranty coverage for any services rendered. Contact your insurance company for guidelines and coverage.**
*Patients are responsible for services not covered by your insurance plan.*

FOR ANY BILLING INQUIRIES

Please contact our Billing office at 630-757-0202

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# PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____

Email Address: _____ Social Security Number: _____

Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer
Choose not to disclose Other gender category not listed

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

**Employment Information**

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext: _____

**Emergency Contact**

Name: _____ Relationship: _____ Phone: _____

**Pharmacy and Labs**

Preferred Pharmacy: _____

Address: _____ Phone: _____

Preferred Lab: _____

Address: _____ Phone: _____

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**Insurance**

***I certify that I have Insurance coverage with***

Primary Insurance: _____

Secondary Insurance: _____

and assign directly to **Srinivas C. Kota, MD** **all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

**The above-named doctor may use my health care information and may disclose such information to the above named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

- ***Please present your insurance card to staff at the front desk.***
  (any changes throughout the year will be the patients responsibility if the office is not informed in a timely manner)

**Financial Policy**

Thank you for selecting Premier Physicians for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

[FOR CASH-ONLY PRACTICES] Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we (E.G., VISA, MASTERCARD, CHECKS, ETC.).

[FOR PRACTICES ACCEPTING INSURANCE] Please be advised that payment for all services will be due at the time of services rendered, unless prior arrangements have been made. We accept some forms of insurance. Please discuss your insurance coverage with a staff member.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Signature Date

_____

Printed Name

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**Srinivas Kota, MDFMNM**
**Diplomate, American Board of Obesity Medicine**
**Diplomate, American Board of Internal Medicine**
**Diplomate, American Board of Metabolic and Nutritional Medicine**

# CONSENT TO TREAT

I _____, authorize the physician and the staff to do any medical treatment, test or care deemed necessary.

Date: _____ Signed: _____
Patient

[illegible]

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# PRIVACY PRACTICES ACKNOWLEDGEMENT

## *ACKNOWLEDGEMENT FORM*

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ DATE OF BIRTH_____

Signature _____

Date_____

****Please ask for copy of Notice of Privacy Practices at the front desk*****

726 S. Weber Road, Bolingbrook, IL 60490 Phone (630) 378-9785 fax (630) 378-9836

**I understand** that the medical providers at Premier Physicians have been trained in a diverse range of diagnostic and treatment options. I understand the that Premier Physicians is highly specialized and based upon evidence-based medicine, including internal medicine, functional medicine and metabolic medicine. As such, they may recommend different tests; may interpret standard tests differently; may propose different treatments, or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases, there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. In addition to conventional internal medicine standard of care, diagnosis and additional treatment(s) may include some services that are considered non-traditional, or nonconventional. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and metabolic medicine.

**As a patient I have the right to be informed about my conditional and recommended care.** This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as whether or not to undergo specific care having had the opportunity to discuss potential benefits, and risks involved.

**I further acknowledge** that no guarantees or assurances have been made to me concerning the results intended from the treatment.

**I understand that the US Food and Drug Administration has not fully evaluated or approved** nutritional or herbal supplements, bio-identical hormone replacement therapies; however, they have been widely used in Europe and US for years. I understand that, as with drugs, hormones, nutritional and herbal supplements may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests. I do not expect the medical provider to be able to anticipate and explain all risks and complications and I wish to rely on the medical provider to exercise judgement in recommending the dietary supplements, medications, and treatment, that the medical provider feels at the time, based on the facts then known, is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired results.

**It is my responsibility to keep my medical provider** up to date with all of the current medications and supplements that I am taking so that he/she can make the best informed recommendations for my care.

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**I hereby request and voluntarily consent to examination and treatment of medical care,** possibly including vitamins, minerals, supplements, detoxification, lab testing, nutrition recommendations, etc for me (or the person named below for whom I am legally responsible) **by Srinivas C Kota MD FMNM ABAARM (Board Certified Internal Medicine and Fellowship Certified in Functional and Metabolic Medicine) .**

**By signing this form**, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Premier Physicians and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment and I may ask my physician for a more detailed explanation at any time.

Print Patient Name

_____

Signature of Patient (or Guardian)

_____

Date Signed

_____

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# NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell) _____ (Work) _____ Gender: M / F
Referred By: _____

**SECTION I: GENERAL HEALTH INFORMATION. MUST BE COMPLETED BY ALL PATIENTS**

**1a) Medical History**

Past medical history (check all that apply):

| | | | |
|---|---|---|---|
| O Heart attack | O Angina | O Gallbladder stones | O Sleep apnea |
| O High blood pressure | O Stroke | O Indigestion/reflux | O Thyroid |
| O High cholesterol | O Diabetes | O Celiac disease | O Anxiety |
| O High triglycerides | O Gout | O Pancreatitis | O Depression |
| O Infertility | O Arthritis | O Polycystic Ovarian Syndrome | O Bipolar |
| O Glaucoma | O Cancer (type/s): _____ | | |

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

O Gastric bypass O Gastric banding O Gastric sleeve O Gallbladder O Heart bypass
O Hysterectomy O Other: _____

**1b) Medication Information**

**Prescription Medications**

| Medication | Strength |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |
| 5._____ | _____ |
| 6._____ | _____ |
| 7._____ | _____ |
| 8._____ | _____ |
| 9._____ | _____ |
| 10._____ | _____ |

**OTC Medications**

Check all the products you use regularly or occasionally:

| | | | |
|---|---|---|---|
| O Aspirin | O Ibuprofen | O Cough suppressant | O Decongestant |
| O Acetaminophen | O Naproxen | O Antihistamine | |

O Sleep aids O Antidiarrheals O Laxatives/ stool softeners O Other:_____
O Antacids O Acid blockers O Diet aids/ weight-loss products

**1c) Allergies:**
(Medications)_____
(Food)_____

**1d) System Review**
(Check all that apply)
O Recent weight ***loss*** more than 10 pounds
O Recent weight ***gain*** more than 10 pounds

| | | |
|---|---|---|
| O Acne | O Skin rash | O Cough |
| O Snoring | O Shortness of breath | O Chest pain |
| O Difficulty breathing when flat | O Fainting/Blacking out | O Palpitations |
| O Swelling ankles/extremities | O Abdominal pain | O Bloating |
| O Constipation | O Diarrhea | O Food intolerance |
| O Dysphagia/difficulty swallowing | O Indigestion | O Nausea/vomiting |
| O Increased appetite | O Decreased appetite | O Heartburn |
| O Gas and bloating | O Urinary frequency/urgency | O Slow urine flow |
| O Nighttime urination | O Blood in stools | O Back pain (upper) |
| O Back pain (lower) | O Joint pain | O Muscle aches/pain |
| O Dizziness | O Headaches | O Seizures |
| O Weakness/low energy | O Anxiety | O Depression |
| O Insomnia | O Memory loss | O Inability to concentrate |
| O Mood changes | O Nervousness | O Loss of interest |
| O Cold intolerance | O Excessive sweating | O Hair changes |
| O Heat intolerance | O Blood clots | O Fatigue/tiredness |

**1e) Social History**
**Smoking**: O Never O Current smoker (_____ packs/day) O Past smoker (quit _____ years ago)
**Alcohol**: O Never O Occasional O Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
**Drugs**: O Never O Current O Past O Type of drugs: _____
**Marijuana**: O Never O Current user (_____ times/day)

Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

**1f) Family History**
**Obesity** (check all that apply): O Mother O Father O Sister O Brother O Daughter O Son
**Diabetes** (check all that apply): O Mother O Father O Sister O Brother O Daughter O Son
Other (check all that apply): O High blood pressure O Heart disease O High cholesterol O High triglycerides O Stroke O Thyroid problems O Anxiety O Depression

○ Bipolar disorder ○ Alcoholism ○ Cancer (type/s): _____
Other: _____

**SECTION II: FEMALE-SPECIFIC HEALTH INFORMATION (For Males Continue to Section III)**

**2a) Gynecologic History**

Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

**2b: Female Symptomatic Concerns**

Check below if you experience any of the following:

□ Fibrocystic breast
□ Weight gain
□ Hot flashes
□ Dry skin/hair
□ Anxiety
□ Depression
□ Breakthrough bleeding
□ Vaginal dryness
□ Headaches
□ Irritability
□ Mood swings
□ Breast tenderness
□ Sleep disturbances/insomnia
□ Cramps
□ Excessive facial hair
□ Fatigue
□ Memory loss
□ Change in bladder habits
□ Arthritis
□ Night sweats
□ Decreased sex drive
□ Fluid retention
□ Hair Loss

**If you checked any of the above, would you like to discuss hormone management therapies?**
Yes/No ( Circle One)

**SECTION III: MALE-SPECIFIC HEALTH INFORMATION (For Females Continue to Section IV)**

**3a) Male Symptomatic Concerns**

Check below if you experience any of the following:

□ Lack of energy
□ Muscle stiffness
□ Decreased erections
□ Irritability
□ Hair loss
□ Poor concentration
□ Loss of drive and competitive edge
□ Depression
□ Decreased sex drive
□ Decreased ability for sports
□ Decreased alertness
□ Loss in height
□ Sleep disturbances/insomnia
□ Fatigue

**If you checked any of the above, would you like to discuss testosterone or erectile dysfunction therapies?** (Circle one) Yes / No

**SECTION IV. COMPLETE THIS SECTION IF YOU HAVE CONCERNS ABOUT WEIGHT MANAGEMENT (If not applicable, continue to "Authorization for Disclosure of Health Information" on page 7.**

**4a) Weight History:**

When did you first notice that you were gaining weight?

O Childhood O Teens O Adulthood O Pregnancy O Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? _____

How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

Life events associated with weight gain (check all that apply):

O Marriage O Divorce O Pregnancy O Abuse O Illness
O Travel O Injury O Nightshift work O Job change O Quitting smoking
O Alcohol O Drugs
O Medication (please list: _____)

Previous weight-loss programs (check all that apply):

O Weight Watchers O Nutrisystem O Jenny Craig O LA Weight Loss O Atkins
O South Beach O Zone diet O Medifast O Dash diet O Paleo diet
O HCG diet O Mediterranean diet O Ornish diet O Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):

O Phentermine (Adipex) O Meridia O Xenecal/Alli O Phen/Fen
O Phendimetrazine (Bontril) O Topamax O Saxenda O Diethylpropion
O Bupropion (Wellbutrin) O Belviq O Qsymia O Contrave

Other (including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

**4b) Nutritional History**

How often do you eat breakfast? _____ days per week at _____: _____ a.m.
Number of times you eat per day: _____ What beverages do you drink? _____
Do you get up at night to eat? Y / N If so, how often? _____ times
List any food intolerances/restrictions: _____

Food triggers (check all that apply):

O Stress O Boredom O Anger O Insomnia O Seeking reward
O Parties O Eating out O Other: _____

Food cravings:
○ Sugar ○ Chocolate ○ Starches ○ Salty ○ Fast food
○ High fat ○ Large portions
Favorite foods: _____

**4c) Personal Health Outcome Goals**

## Why I Want to Lose Weight…

Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Ensure that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to lose weight:

1._____

2._____

3._____

4._____

5._____

Describe the physical benefits you hope to get by losing weight:
_____
_____

Describe the functional benefits you hope to get by losing weight:
_____
_____

Describe the medical benefits you hope to get by losing weight:
_____
_____

Describe the psychological benefits you hope to get by losing weight:
_____
_____

Comments:
_____
_____

# How I Plan to Lose Weight…

Goal setting is the "how" of weight loss. Motivators are the "why." When setting goals, utilize the SMART technique:

| SMART | Technique | Example |
|---|---|---|
| Specific | Who, what, where, when, how… | "I want to lose 10 pounds in two months." |
| Measureable | How will you track? | 10 pounds in 8 weeks = 1.25 pounds/week |
| Attainable | Resources you have available, previous experience | "I have been able to do this before, and now I have new tools from my doctor!" |
| Relevant | Why this goal is important | Review your motivators |
| Timely | Set benchmarks and deadlines | "Focusing for two month intervals works for me." |

Please list three goals you would like to achieve during your treatment:

1._____

2._____

3._____

**SECTION V: MUST BE COMPLETED BY *ALL* PATIENTS**

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: (First) _____ (Last) _____
Date of birth: _____/_____/_____ SSN: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. *I authorize the use or disclosure of the above-named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure.*

Practice Name: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. The type and amount of information to be used or disclosed is as follows:
   - ○ Complete health records
   - ○ Physical exam
   - ○ Immunization record
   - ○ Lab results/X-ray reports
   - ○ Consultation reports
   - ○ Other (please specify): _____
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
   *This information may be disclosed to and used by* Premier Physicians*,* 726 S. Weber Rd, Bolingbrook, IL 60490 *for the purpose of*
   _____
3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
4. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Premier Physicians.

_____
Patient's Name (printed) Date

_____
Patient Signature *(or signature of person with authority to consent for patient)*