

Greetings!

We are happy that you are considering the Working Off Weight (WOW) Program at Munson Healthy Weight Center to help you adopt a new, healthy lifestyle. According to the American Heart Association, being overweight or obese is a major risk factor for the development of heart disease, high blood pressure, diabetes, joint problems, gall bladder disease, some types of cancer and many other diseases. Losing weight can help you reduce your risk for these diseases. If you already have one or more chronic disease, losing weight can help you better manage your condition. Our program, depending on the plan selected, can help you lose from 7% to >20% of your weight over a six month period. Some patients can lose even more than this.

Enclosed, you will find a Registration Form, Enrollment Form, Referral Form and a packet of information outlining our meal plan selections and maintenance plan options. You must complete each form and bring them with you to your Orientation Class. In addition, **please bring a copy of your latest chemistry profile, lipid panel, TSH and HbA1c report.** If you have not had these lab values checked in the past **six** months, please do so with your primary care provider.

It is important that you review the Meal Plan Options packet and come to the Orientation Class prepared to choose a meal plan. At the Orientation, our staff will outline each plan in detail. You will be asked to choose and commit to a meal plan during your Orientation Class. If you are unsure of which plan to choose, our staff will assist you in choosing the plan most appropriate for you.

All package costs are to be paid at the first visit following the Orientation. The Orientation fee is \$20 (Checks and cash only please).

- You are registered for our next Orientation Class on:
- Please call **(231) 935-8533** to register for our next Orientation class on:

Munson Community Health Center - Conference Rooms A & B
5:30 pm – 6 pm Registration
6 pm - 8:30 pm Orientation Presentation
Cost: \$20

At the end of the orientation you will be scheduled for your first appointment with our staff. Please bring your planning calendar to expedite the scheduling process. Space is limited, so if you cannot attend, please contact our office immediately at **(231) 935-8533** and we will reschedule you for another class. Please park in the MCHC Urgent Care parking lot and follow signs to the Healthy Weight Center Orientation Class.

If you have questions or concerns, please contact our office and someone will be happy to answer your questions.

We are looking forward to working with you.

Sarah Wetmore, M.A., CES
Coordinator
Healthy Weight Center
(231) 935-8533 (phone)
(231) 935-8609 (fax)

MUNSON MEDICAL CENTER

Healthy Weight Center

Registration Form

Patient Initials: _____

In order for us to process your registration form quickly and accurately, please print legibly and be sure to complete the entire form. If you have questions please ask for assistance.

(circle one)

Mr. Ms. Mrs. Dr. First Name: _____ MI: ____ Last Name: _____

(circle one)

Male | Female DOB: ____/____/____ E-Mail Address: _____

Address (include apartment or unit #): _____

City: _____ State (Province): _____

Zip (Postal Code): _____ Country: _____

Home Phone (include area code): _____ Other Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Physician: _____ Physician Phone: _____

For which Healthy Weight Center program are you registering? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program

In order to have access to the web site and program support features you must select a unique username and password, as well as a reminder question and answer in case you lose your password. Your **Username** can contain letters and numbers only (no special characters) and your **Password** should not be something easily guessed (but something easily remembered).

NOTE – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.

Username: _____ Password: _____

Choose one of the following **Reminder Questions** by placing a checkmark in the appropriate box:

- What is your mother's maiden name?
- What was the name of your first pet?
- Whom do you most admire?
- What elementary school did you attend?

Record your answer here: _____

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: _____ Date: _____

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form prior to the orientation meeting. If you are unsure of what to do please ask for assistance from a staff member at the orientation.

First Name: _____ Last Name: _____ DOB: ____/____/____

What was your weight at age 18? _____ Highest adult weight? _____ Lowest adult weight? _____

If you could weigh whatever you wanted, what would your "dream weight" be? _____

At what weight do you feel you would be happy? _____ What weight would be "acceptable" to you? _____

At what weight (less than your current weight) would you still be disappointed? _____

What weight do you have in mind to achieve as your "goal weight" through this program? _____

Please indicate which weight loss medications you have used in the past (check all that apply):

- | | | |
|---|--|-------------------------------|
| <input type="checkbox"/> Phentermine | <input type="checkbox"/> Meridia® | <input type="checkbox"/> None |
| <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Xenical® | |
| <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Wellbutrin | |
| <input type="checkbox"/> Phen/Fen combination | <input type="checkbox"/> Other (list): _____ | |

Are you pregnant? Yes No NA Are you planning a pregnancy in the near future? Yes No NA

Are you currently breast feeding (lactating)? Yes No NA

Indicate which of the following conditions you have suffered or currently suffer from (choose all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> GERD (acid reflux) |
| <input type="checkbox"/> Heart Valvular Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> None |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Type 2 Diabetes | <input type="checkbox"/> Other (list types below) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> NASH (fatty liver) | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Liver Disease (severe) | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Cancer (list types below) | <input type="checkbox"/> Gout | |

Other diseases or illnesses: _____

Types of cancer: _____

Smoking? (choose one):

Never smoked Quit smoking Less than pack/day Up to 2 packs/day More than 2 packs/day

If you smoke or used to smoke, How long? _____ yrs. If you quit smoking, when? (date) _____

Do you use alcohol? (choose one):

Never Quit drinking Less than 3 drinks/week Up to 14 drinks/week More than 14 drinks/week

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Has any member of your immediate family (parents, brothers, sisters) ever had: (choose all that apply):

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> None |
| <input type="checkbox"/> Diabetes (type 1 or type 2) | <input type="checkbox"/> Colon Cancer | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Prostate Cancer | |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other Cancer _____ | |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (list): _____ | |

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

- | | | |
|--|---|-------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> for Depression | <input type="checkbox"/> None |
| <input type="checkbox"/> for Weight Loss | <input type="checkbox"/> for Anxiety | |
| <input type="checkbox"/> for High Blood Pressure | <input type="checkbox"/> for Sleep | |
| <input type="checkbox"/> for Heart Disease | <input type="checkbox"/> for Hypothyroidism | |
| <input type="checkbox"/> for Birth Control | <input type="checkbox"/> for Gout | |
| <input type="checkbox"/> for Hormone Replacement | <input type="checkbox"/> for Allergies | |
| <input type="checkbox"/> for Diabetes | <input type="checkbox"/> OTHER | |

List ALL medication you are currently taking in the box below (prescription and over the counter, including vitamins – include the name of the medication, dosage, and frequency for each medicine): I am not taking any prescription medications.

List any medication allergies: _____ None

List any food allergies: _____ None

List any hospitalizations for surgery, major illness or injury that required an overnight stay (include date):

_____ None

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Indicate what symptoms you are currently experiencing (choose all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Vaginal bleeding |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Unusual skin lumps |
| <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Breast lumps or changes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain in hands |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain in feet |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Pain in hips |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain in knees |
| <input type="checkbox"/> Indigestion/Nausea | <input type="checkbox"/> Pain in back |
| <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Pain in neck |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Pain in shoulder |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain in elbow |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Trouble walking |
| <input type="checkbox"/> Other (list): _____ | |
| <input type="checkbox"/> None | |

Do you have a history of: (choose all that apply)

- | | | | |
|---------------------|--------------------------------|-------------------------------|----------------------------------|
| Anorexia | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Bulimia | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Binge eating | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Incest/sexual abuse | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |

Once you have completed page two through page five of this enrollment form, be sure to add your initials to the top left corner of all four pages. Page six and seven will be completed by a staff member at the conclusion of your Orientation Class.

Important Note – You must hand in your registration and enrollment forms, as well as your physician's authorization before your program start appointment will be scheduled. If you have any questions, please contact one of the Munson Medical Healthy Weight Center staff members.

Hint – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: _____ Date: _____

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form

Patient Initials: _____

STAFF USE ONLY

Physical Exam Worksheet

Patient Name of Record: _____

EMR Identification Number: _____

Height: _____ inches Weight: _____ lbs. Waist Circumference: _____ inches

Hip Circumference: _____ inches BP: _____/_____ Heart Rate: _____ bpm.

Lab values: Labs recorded below (drawn on: ___/___/___) Labs requested Labs not required

Tot Cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____

Hgb A1c: _____ Fasting Glucose: _____ Thyroid (TSH) : _____

For which Healthy Weight Center program is this patient enrolling? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program
- Healthy Weight – 8 week program

Visit setting: Individual session Group session

These GOAL Weight entries require body mass measurements - DO NOT record weight LOSS goals

Initial weight goal: I want to weigh _____ lbs. in 4 weeks

Long-term weight goal: I want to weigh _____ lbs. eventually

Motivations to lose weight (choose two)

- improve health improve appearance feel better live longer
- wishes of family members wishes of friends or others

OTHER (not listed): _____

Barriers to success (choose two)

- exercise lack of motivation poor food preparation poor food choices
- inability to control eating/portion sizes lack of time money
- lack of support from family or others

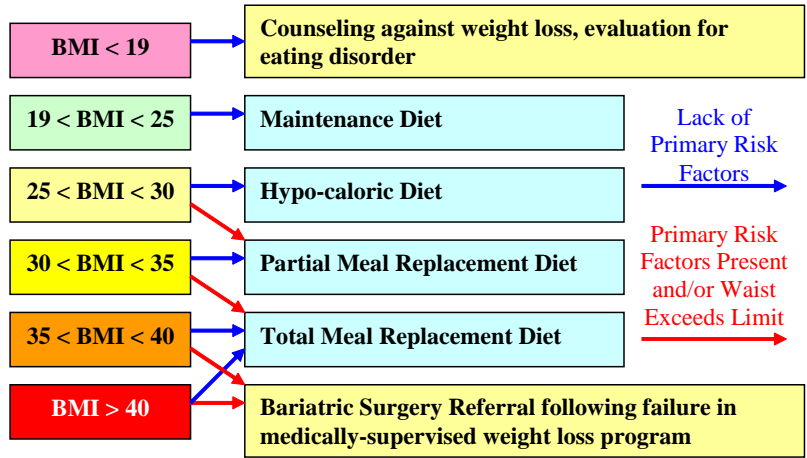
OTHER (not listed): _____

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Treatment Plan Protocol



Treatment Plan (choose one):

- Total Meal Replacement** (full supplements – estimated rate of loss 3-5 lbs/wk)
- Partial Meal Replacement** (partial supplements with food plan – estimated rate of loss 2-3 lbs/wk)
- Hypo-caloric** (no supplements with 700 cal deficit whole food plan – estimated rate of loss 1-2 lbs/wk)

If the Treatment plan is not selected according to this protocol, please indicate the reason for your choice:

- PCP Preference
 Patient Preference
 Comorbidity
 Financial Considerations
 Supplement Intolerance
 Other: _____

Physician consent received? Yes No n/a (non-supplemented plan)

Has a start date appointment been scheduled? Yes No Date of the appointment: ____/____/____

Other comments:

Staff member (signature): _____

Staff member (please print): _____ Date of service: ____/____/____

MUNSON MEDICAL CENTER

Healthy Weight Center

Meal Plan Options

All diet plans are supported by medical research as effective means for losing weight.

Meal Plan: Hypocaloric

This plan has been designed to provide optimum nutrition that will help you lose or control your weight and maintain health. Along with regular exercise and lifestyle education, this plan is designed to help you lose 1-2 pounds per week, although results may vary from person to person. This plan includes the use of whole foods that are portion based on food groups and calorie content, but can also include the use of meal replacement supplements. The calorie range for this plan is 1,200 to 1,600 calories per day. Eating from a wide variety of foods provides better overall nutrition.

Cost: \$430 (plus \$20 orientation fee) covering initial four months and including:

3 sessions with a Registered Dietician
4 sessions with an Exercise Specialist
4 group classes (nutrition or behavioral health)
Unlimited use of Internet program
Access to long-term, online support

Meal Plan: Partial Meal Replacement

This plan uses a structured diet of pre-packaged entrees (purchased at the grocery store), dairy products, fruits and vegetables, plus approximately 4 packets of meal replacement supplements (purchased from our vendor) per day. This plan along with regular exercise and lifestyle education is designed to help you lose 2-3 pounds per week. The calorie range for this is 1,000-1,200 calories per day. This plan may be recommended for those who are 25 to 50 pounds overweight.

Cost: \$430 (plus \$20 orientation fee) covering initial four months and including:

3 sessions with a Registered Dietician
4 sessions with an Exercise Specialist
4 group classes (nutrition or behavioral health)
Unlimited use of Internet program
Access to long-term, online support

There is an additional cost of approximately \$41-62 per week for supplements.

Meal Plan: Total Meal Replacement

This plan exclusively uses protein based meal replacement supplements. The typical plan equals 600-800 calories per day. For safe progress, patients on this plan may be required to make and attend follow-up visits at the Healthy Weight Center Clinic with our program Medical Director, or with your own Primary Care Provider. These appointments are not included in the program fee. This plan along with regular exercise and lifestyle education is designed to help you lose 3-5 pounds per week and is best for those who are 25-100+ pounds overweight.

Cost: \$430 (plus \$20 orientation fee) covering initial four months and including:

3 sessions with a Registered Dietician
4 sessions with an Exercise Specialist
4 group classes (nutrition or behavioral health)
Unlimited use of Internet program
Access to long-term, online support

There is an additional cost of approximately \$65-88 per week for supplements.

MUNSON MEDICAL CENTER

Healthy Weight Center

Maintenance/Continuation Program Packages

At the conclusion of the initial four-month session, patients may opt to continue follow-up with an exercise specialist, registered dietician or behavioral health specialist in order to maintain or continue their weight loss efforts. Many studies have shown that long-term follow-up leads to continued weight loss and successful weight maintenance. The options each patient may select are listed below with associated costs. All costs are to be paid up front at the first session. All sessions are scheduled as needed by contacting our office. Supervised Exercise Sessions may be purchased by the month.

Healthy Lifestyle Maintenance Plan

Cost: \$200 for 4 months

2 individual sessions with an exercise specialist
2 individual sessions with a Registered Dietician
4 supervised exercise sessions with an exercise specialist
Unlimited use of Internet program
Access to long-term online support

Supervised Exercise Sessions

\$6.20 each one hour and fifteen minute session

This optional exercise session is a fantastic and affordable way to fine-tune your workout sessions. Sessions are offered at several time blocks, three days a week (see schedule for exact times). Patients have the option to be weighed at the beginning of each session. Up to 8 participants may be scheduled at each one hour and fifteen minute time block. Our Certified Exercise Specialist will be available to assist you with your workout. You may schedule these sessions at any time by contacting our department secretary.

These sessions can be purchased in blocks of 4 and payment is due prior to your first session.

Registered Dietician Follow-up

\$55 for one 30-minute session with any of our Registered Dieticians

Individual Exercise Session

\$20.80 for one 30-minute session with our Certified Exercise Specialist

Group Exercise Session (Circuit Training)

\$12.40 for each one-hour session

MUNSON MEDICAL CENTER

Healthy Weight Center

Program Referral Form: W.O.W. Program

Dear Primary Care Provider,

The Munson Healthy Weight Center is a physician supervised weight management clinic offering a range of treatment options that follow National Institutes of Health guidelines for the treatment of overweight and obesity. Treatment plan options range from nutrition education to a total meal replacement plan. Plans are matched with patients according to preference and medical appropriateness under the supervision of a physician and in accordance with NIH guidelines. In order to qualify for participation, your patient requests your approval by signing below. If your patient requests to be placed on the TOTAL MEAL REPLACEMENT plan, **you must check the box below.**

We ask that each candidate be cleared of uncontrolled medical conditions that would take precedence over weight loss efforts. If available, please forward their most recent lab values including a chemistry profile, a lipid panel, TSH (and HbA1c if appropriate) to assist us in medically monitoring their safety during their weight loss program. Patients placed on the total meal replacement plan will require routine lab value monitoring. With your permission, our medical director would be happy to see your patient throughout their weight loss program for routine lab monitoring. All lab results and medication (anti-hypertensives, oral hypoglycemics) changes will be communicated with you.

WILL YOU ALLOW YOUR PATIENT TO BE PLACED ON A TOTAL MEAL REPLACEMENT PLAN AS BRIEFLY DESCRIBED BELOW?

TOTAL MEAL REPLACEMENT PLAN

- 600-800 calories/day
- 70 grams of Protein/day
- Use of nutritionally complete meal replacements (approx. \$65-88 per week)
- Recommended for > 25 lb. loss

Yes No

If you would like our medical director to see your patient for routine follow-up visits regarding their weight loss process and to make medication changes for you, please indicate your approval by checking the appropriate box.

Yes No

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____ Patient Phone #: _____

Physician Signature: _____ Physician Name (Print): _____

Date: _____ Physician Phone #: _____ Physician Fax #: _____

To enroll in the Working Off Weight (W.O.W.) program, your patient must be scheduled into and attend an information/orientation class. The class fee is \$20.00, which is generally an out-of-pocket expense.

- Faxing this form to (231) 935-8609 will begin the enrollment process.
- If the patient wishes to take some time to consider the W.O.W. program, they may enroll themselves by calling the number below and faxing the form.

If the patient received this form in a packet, he/she must bring this form, along with the enrollment and registration forms, to the orientation class.