

Greetings!

We are happy that you are considering the 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 diseases, 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:

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**Munson Community Health Center - Conference Rooms A & B**  
**6 pm - 8:30 pm**  
**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
- Healthy Weight – 8 week 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"/> 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"/> Other (list types below) |
| <input type="checkbox"/> Bowel Disease             | <input type="checkbox"/> Type 2 Diabetes     |   |
| <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"/> 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"/> 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):

List any medication allergies: \_\_\_\_\_

List any food allergies: \_\_\_\_\_

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

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# 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): _____ |  |

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

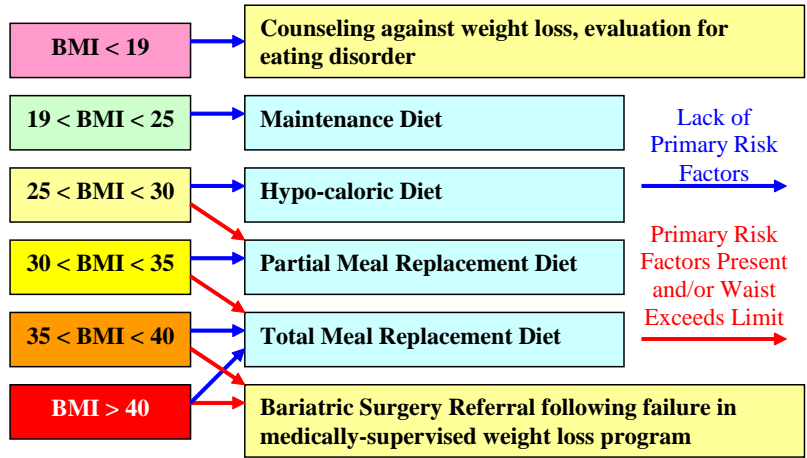
OTHER (not listed): \_\_\_\_\_

# Healthy Weight Center

Enrollment Form

Patient Initials: \_\_\_\_\_

### Treatment Plan Protocol



### Treatment Plan (choose one):

- Total Meal Replacement** (full supplements – estimated rate of loss 4-7 lbs/wk)
- Partial Meal Replacement** (partial supplements with food plan – estimated rate of loss 2-3 lbs/wk)
- Hypo-caloric** (partial supplements with 700 cal deficit 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. This plan, along with regular exercise and lifestyle education 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 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: \$425 (plus \$20 orientation fee) covering initial four months and including:**

3 sessions with a Registered Dietician  
4 sessions with an Exercise Specialist  
5 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 protein-based supplement (purchased from betterMD.net) per day. This plan along with regular exercise and lifestyle education is designed to help you lose 2-3 pounds per week. This plan includes servings of whole food and the use of meal replacement supplements. 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 (10-15% of your current weight).

**Cost: \$425 (plus \$20 orientation fee) covering initial four months and including:**

3 sessions with a Registered Dietician  
4 sessions with an Exercise Specialist  
5 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 nutritional supplements. The typical plan equals 500-800 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. Potential weight loss is 20% to over 35% of your current body weight (best for those who are 25-100+ pounds overweight).

**Cost: \$425 (plus \$20 orientation fee) covering initial four months and including:**

3 sessions with a Registered Dietician  
4 sessions with an Exercise Specialist  
5 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 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 12 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**

\$60 for one 30-minute session with any of our Registered Dieticians

#### **Individual Exercise Session**

\$20 for one 30-minute session with our Certified Exercise Specialist

#### **Group Education Session**

\$21 for each group education session taught by our Registered Dietician or Behavioral Health Specialist

#### **Group Exercise Session (Circuit Training)**

\$12 for each one-hour session.

# MUNSON MEDICAL CENTER

## Healthy Weight Center

### Staff Hours of Operation

#### Monday

Behavioral Health (Julie)	8 am	-	1 pm (closed at 1)
Dietician (Connie)	8:30 am	-	12 pm (closed at 12)
Supervised Exercise (Sarah)	11:15 am	-	12:30 pm

#### Tuesday

<b>Dieticians</b>			
Laura	10 am	-	12 pm (closed for lunch)
	1 pm	-	6:30 pm (closed at 6:30)
Patti	3:30 pm	-	6:30 pm (closed at 6:30pm)
Individual Exercise (Sarah)	3 pm	-	7pm (closed at 7)

#### Wednesday

Individual Exercise (Sarah)	8 am	-	12:30pm (closed at 12:30)
Supervised Exercise (Ron)	3:15 pm	-	4:30 pm
	4:45 pm	-	6:00 pm
	6:15 pm	-	7:30 pm
Behavioral Health (Vince)	8:00 am	-	12:00 pm (closed at 12:00)

#### Thursday

Individual Exercise (Sarah)	7:30 am	-	11 am (closed at 11)
Individual Exercise (Ron)	7am	-	11am (closed at 11)
Behavioral Health (Julie)	2:30 pm	-	4:30 pm (every other week)
	2:30 pm	-	6:30 pm (every other week)
<b>Dieticians</b>			
Patti (1 <sup>st</sup> & 2 <sup>nd</sup> Thurs.)	2:30 pm	-	5 pm (closed at 5)
Patti (3 <sup>rd</sup> , 4 <sup>th</sup> & 5 <sup>th</sup> Thurs.)	2 pm	-	5 pm (closed at 5)
Laura (every other week)	4:30 pm	-	7:30 pm (closed at 7:30)
	4:30 pm	-	5 pm (Group Ed 5:30-6:30)
	7 pm	-	7:30 pm (closed at 7:30)

#### Friday

Supervised Exercise (Ron)	7:00 am	-	8:15 am
	8:30 am	-	9:45 am
	10 am	-	11:15 pm
Individual Exercise (Sarah)	7:30 am	-	9 am (closed at 9)

**Follow-up dietician appointments are 30 minutes, exercise 30 minutes and behavioral health 50 minutes. All supervised exercise appointments are 1 hour and 15 minutes.**



HEALTHY WEIGHT CENTER

Phone: (231) 935-8533

Fax: (231) 935-8609

## WORKING OFF WEIGHT PROGRAM REFERRAL

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 (antihypertensives, 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**

- 500-800 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 above 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.***