Andre Y. Levesque, MD
Board Certified Plastic Surgeon

WEIGHT LOSS PROGRAM INTAKE FORMS

Full Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact Information: _____

SEX	STATUS	SMOKING	ALCOHOL	TIMEFRAME
❍ MALE	❍ SINGLE	❍ CURRENT	❍ 0 DRINKS PER WEEK	❍ ASAP
❍ FEMALE	❍ MARRIED	❍ NEVER	❍ 1-5 DRINKS PER WEEK	❍ 1-3 MONTHS
❍ TRANSGENDER	❍ WIDOWED	❍ PREVIOUS	❍ 5-10 DRINKS PER WEEK	❍ 6-12 MONTHS
❍ NONBINARY	❍ DIVORCED	YEAR QUIT:	❍ 15+ DRINKS PER WEEK	❍ UNDECIDED
❍ NO RESPONSE		_____		

HEIGHT: _____ WEIGHT:_____ ALLERGIES: _____

CURRENT MEDICATIONS: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

PHYSICIAN ADDRESS: _____

REFERRAL SOURCE:

❍ FRIEND: _____ MAY WE THANK THEM ❍ YES ❍ NO

❍ SOCIAL MEDIA: ❍ INSTAGRAM ❍ FACEBOOK ❍ TIKTOK

❍ GOOGLE SEARCH: _____ ❍ OTHER: _____

PAST HEALTH HISTORY

PREVIOUS OR CURRENT CONDITIONS (check all that apply):

	ASTHMA		ACID REFLUX		HIGH BLOOD PRESSURE		DEPRESSION
	COPD		KIDNEY DISEASE		HEART DISEASE		ANXIETY
	SLEEP APNEA		ANEMIA		CHRONIC LEG SWELLING		THYROID PROBLEMS
	PTSD		BULIMIA		BLEEDING DISORDER		BINGE EATING DISORDER
	GOUT		LIVER DISEASE		BLOOD CLOT		ANOREXIA NERVOSA
	FIBROMYALGIA		FATTY LIVER		GALLBLADDER DISEASE		URINARY INCONTINENCE
	ARTHRITIS		ULCERATIVE COLITIS		HEADACHES/MIGRAINES		ADHD/ADD
	OSTEOPOROSIS		CROHN'S DISEASE		POLYCYSTIC OVARIES		IRRITABLE BOWEL SYNDROME
	CANCER		BIPOLAR		MENOPAUSE		ALCOHOL/DRUG ABUSE
	DIABETES		STOMACH ULCERS		OTHER:		

Andre Y. Levesque, MD
Board Certified Plastic Surgeon

WEIGHT LOSS PROGRAM INTAKE FORMS

PREVIOUS SURGERIES:

TYPE:	MONTH, YEAR:

HOSPITALIZATIONS:

REASON:	HOSPITAL NAME:	MONTH, YEAR:

FAMILY HEALTH HISTORY:

	HEART ATTACK ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	STROKE ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	DIABETES ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	CANCER ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	PSYCHIATRIC ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	OBESITY ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT
	OTHER: _____ ❍ FATHER ❍ MOTHER ❍ SIBLING ❍ AUNT/UNCLE ❍ GRANDPARENT

COMPLIANCE ASSURANCE NOTICE

To our Valued Patients:

Electronic Communication Notice: Dr. Levesque is happy to communicate with you via email, Doximity or any electronic communication when you request a consultation or have questions or concerns. If you initiate electronic communication rather than the alternative of an in-person consultation or talking to Dr. Levesque by phone, you accept the risks of using unsecured electronic communications, which could result in the intercepting of protected health information (PHI) by unaffiliated parties.

Thank you,
Andre Levesque, M.D. and Staff

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Andre Y. Levesque, MD
Board Certified Plastic Surgeon

WEIGHT LOSS PROGRAM INTAKE FORMS

Financial Procedures for Weight Management

All fees are payable in advance. All major credit cards are accepted through the DrWell Portal.

There are no refunds once services are rendered.

CONSULTATION:
There is a $100 weight management non-refundable consultation fee. This fee is charged at the time you schedule your consultation. This fee is non-refundable and is not applied to any medication costs or other treatments. The consultation fee covers the time spent with the doctor during your evaluation.

You can reschedule your consultation appointment **once** without penalty. If you reschedule a second time, you will be charged an additional $100 consultation fee. Missing appointments will result in termination from our weight management program.

APPOINTMENT CANCELLATIONS:
Our office strictly enforces a 48-hour cancellation policy for consultations. Meaning that to receive a refund for a previously scheduled consultation, you must cancel *at least 48 hours prior* to your consultation. If you are unable to keep an appointment you must call our office at least 48 hours in advance to avoid losing your $100 consultation fee. To reach us after-hours, please call the office and leave a message. We will retrieve your time-stamped message on the following business day and process your request if possible.

WEIGHT MANAGEMENT PROGRAM & MEDICATION FEES:

The 6-month weight management program is designed to provide information via email on diet, exercise and other behavioral changes to help you during your weight loss journey with Levesque Plastic Surgery.

Medications are only prescribed after your consultation and review of your medical history and lab work.

Our Weight Management program will be charged separately through our online subscription service (link will be provided after your eval). Enrollment in our weight management program will allow automated processing of the credit card on file every month (or specified time period) followed by shipment of your medication. Enrollment in our weight management program can be cancelled at any time. Medication supplies subject to availability.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

INFORMED CONSENT FOR USE OF TELEHEALTH WITH DR ANDRE LEVESQUE

FULL NAME: _____ DATE OF BIRTH: _____
PATIENT LOCATION: _____

WHAT IS TELEHEALTH?

Telehealth is the use of audio, video, or other electronic communications to provide care when you and your healthcare provider are at different locations. At present our office only provides services to patients who reside in the state of Texas. During your telehealth visit, your medical history and personal health information may be discussed and a physical examination of you may take place. Additionally, video, audio, and/or photo recordings may be taken.

HOW DOES OUR OFFICE USE TELEHEALTH? We offer Doximity for initial consults and follow up visits. This platform offers encryption to minimize the risk of privacy intrusion.
ARE TELEHEALTH VISITS SECURE?

Levesque
PLASTIC SURGERY

Andre Y. Levesque, MD
Board Certified Plastic Surgeon

WEIGHT LOSS PROGRAM INTAKE FORMS

We value your privacy and will make every effort to use electronic systems with network and software security protocols to protect the privacy and security of your health information. To ensure security, patients should use anti-virus/malware safeguards on their devices and password-protected internet connections.

WHAT ARE THE ANTICIPATED BENEFITS OF TELEHEALTH VISITS?

- Increased access to medical care
- Reduced commuting and wait times
- Helps to reduce the spread of infectious disease

WHAT ARE THE POTENTIAL RISKS ASSOCIATED WITH TELEHEALTH VISITS?

As with any medical procedure, there are potential risks associated with telehealth visits. These risks include, but may not be limited to:

- Clinical limitations such as the need for an additional in-office visit for measurements or photos
- Despite reasonable efforts on our part, the transmission of information could be disrupted

By signing this form, I understand the following:

(please initial before each statement)

	Telehealth involves the communication of my health information in an electronic or technology-assisted format.
	All electronic communications carry some level of risk. I can expect the anticipated benefits from the use of telehealth; however, no results can be guaranteed.
	I must take reasonable steps to protect myself from the unauthorized use of my electronic communications by others.
	I have the right to inspect information obtained and recorded in the course of a telehealth visit and may receive copies of this information for a reasonable fee.
	A medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
	I may withhold or withdraw consent to a telehealth visit at any time before and/or during the visit without affecting my right to future care or treatment.
	Alternative methods of medical care are available to me, and I may choose one or more of these at any time.

PATIENT CONSENT TO USE OF TELEHEALTH

I have read and understand the information provided above, have discussed it with my healthcare provider, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telehealth in my medical care.

REFUSAL

☐ I refuse to participate in a telehealth visit as described above.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____