What Is WeCare?

WE care is a Medically Supervised Weight Loss and Exercise Management practice offered by Community Care Physicians, P.C.

What Should I Expect at my First Visit?

- You will meet with one of our providers and members of our staff for an extended 90-120 minute appointment.
- You will have a comprehensive evaluation that will include review of your medical, weight, nutrition, exercise, and behavioral history.
- We will discuss weight and exercise goals with you and develop a plan for both.
- You will have a cardiovascular risk assessment. Depending on your risk assessment, we may refer you for a stress test, echocardiogram, or cardiology evaluation.
- We will make exercise recommendations for you including cardio-respiratory, resistance, and stretching.
- You will receive nutritional counseling.
- Past lab work will be reviewed and additional labs ordered if needed.

How Often Do I Follow Up?

Depending on your needs, we will see you approximately every 4 weeks during your active weight loss phase. These visits are 30 minute visits.

What Should I Expect at My Follow Up?

- At each appointment, you will see one of our providers (physician, nurse practitioner, or dietician).
- You will have your weight, BMI, and body composition measured.
- Your diet plan, behavior, and exercise program will be evaluated at each visit and revised if needed.

How Long Will I be in the Program?

- Our goal is to continue to see our patients after they have achieved their weight loss goals for a minimum of 2 years.
- During this time, patients will be seen every 3-6 months.
- If weight gain or unhealthy habits return, patients will be seen more frequently according to their needs.

Will My Insurance Cover this?

- WeCare is covered by most major insurance carriers.
- We require a referral from your Primary Care Provider; this verifies your individual insurance coverage specifically for our program.
- Certain Insurance plans may have restrictions regarding the number of visits that they allow and/or diagnosis used.
- Patients are responsible for their co-pay at the time of their office visit.

What Does My Insurance Cover?

- Initial comprehensive consultation
- EKG
- Labs
- Follow up appointments in the active weight loss and maintenance phases
- Nutritional Counseling
- Resting Metabolic Rate Analysis (if indicated)
WE CARE PRE-VISIT QUESTIONNAIRE

Thank you for your interest in WEcare, the medically supervised weight and exercise management program at Community Care. In order for us to prepare for your appointment, we require that you complete this pre-visit questionnaire. Please answer all questions completely and honestly.

We ask that this questionnaire be completed and returned to the office at least 1 week prior to your initial appointment.

If your primary care physician is not part of Community Care, we require records from your primary care provider. We need to receive these records at least 1 week prior to your initial appointment. Please use the medical release form attached to this packet.

If we are missing your questionnaire or your primary care records, you may be contacted to reschedule your appointment.

Your initial appointment will be an extended visit with one of our physicians or nurse practitioners (Dr Katherine Stam DO, Raymond Carrelle MD, Laura Reutzel FNP, or Linda Katz FNP). Because your first appointment requires a consultation with one of our providers and additional counseling with our staff, please expect to be at our office for 1.5-2 hours. Additionally, most patients will require an EKG at their initial appointment.

Remember to bring your ID (driver’s license) and your insurance card. You can wear street clothes, as you will not be exercising at your initial appointment.

Some patients may require additional clearance to start an exercise program that may include stress testing or cardiology evaluation.

PLEASE RETURN THIS FORM TO:

WEcare
713 Troy Schenectady Road, Ste 215
Latham, NY 12110
FAX: (518) 713-5359

Your Name: ___________________________________ DOB_________________ Gender: M F
Phone #: ______________________________________
Date of Initial Appointment: ______________________
Primary Care Physician: ____________________________
Specialists: _____________________________________________________________________________
MEDICAL HISTORY: (PLEASE MARK ALL THAT APPLY)

☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Problems - Heart Attack, Coronary Disease, Valve Problems, Congestive Heart Failure, Cardiomyopathy, other:

☐ Cerebrovascular Disease - Stroke, Mini-Stroke, Carotid Artery Disease, other:

☐ Peripheral Vascular Disease
☐ Lung Problems - COPD, Asthma, pulmonary hypertension, interstitial lung disease, restrictive lung disease, other:

☐ Sleep Problems - Insomnia, Snoring, Sleep Apnea, CPAP, other:

☐ Diabetes
☐ Thyroid Problems - under or over active thyroid, thyroiditis, thyroid nodule, thyroid removed, other:

☐ Kidney Disease - kidney failure, protein in urine, nephritis, polycystic kidneys, other:

☐ Kidney Stones
☐ Liver Disease - Hepatitis, Fatty Liver, Cirrhosis, other:

☐ Gout
☐ Gallstones

☐ GYN Problems - Polycystic Ovarian Syndrome, Irregular Menses, other:

☐ Infertility
☐ Osteoarthritis - Back, Neck, Hips, Knees, Feet, other:

☐ Rheumatologic Disorder - Rheumatoid Arthritis, Lupus, Sarcoidosis, Fibromyalgia, other

☐ Mood Disorder - Anxiety, Depression, Stress, Bipolar Disorder, other

☐ Cancer - type

☐ Eating Disorder - Anorexia, Bulimia, Binge Eating, Night Eating, other

☐ Neurological Disorder - Seizures, Migraine, Neuropathy, RSD, other

☐ Gastrointestinal Problems - Irritable Bowel, Inflammatory Bowel, Colitis, Diverticulitis, Celiac Disease, Reflux, Constipation, other

☐ Addiction - type

☐ Other

WHAT IS YOUR MOTIVATION TO LOSE WEIGHT?

☐ Health
☐ Appearance
☐ Reduce Medications
☐ Improve Mobility and Exercise Tolerance
☐ Other

WHAT IS THE MOST YOU HAVE EVER WEIGHED? ____________________ AT WHAT AGE? ____________________

WERE YOUR overweight or obese as an adolescent? (CIRCLE) YES NO

WHAT WAS YOUR WEIGHT AT THE TIME OF YOUR HIGH SCHOOL GRADUATION? ____________________

HAVE YOU GAINED WEIGHT IN THE PAST YEAR? (CIRCLE) YES NO

☐ If yes, how much weight have you gained? ____________________

☐ If yes, have you had any major life changes in the past year? ____________________

WHAT IS YOUR PERSONAL GOAL WEIGHT? ____________________

WHAT DIETS HAVE BEEN MOST SUCCESSFUL FOR YOU IN THE PAST AND WHY?

______________________________

______________________________

______________________________
**WHY HAVE PREVIOUS DIETS FAILED?**

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**HAVE YOU EVER BEEN ON A VERY LOW CALORIE DIET (LESS THAN 1000 CAL / DAY)? (CIRCLE) YES NO**

- If yes, when: __________________________

**HAVE YOU HAD ANY SURGICAL BARIATRIC PROCEDURES? (CIRCLE) YES NO**

- If yes, explain: ____________________________________________________________

**HAVE YOU EVER TAKEN OVER THE COUNTER SUPPLEMENTS FOR WEIGHT LOSS? (CIRCLE) YES NO**

- If yes, what supplement: ____________________________________________________

**HAVE YOU EVER TAKEN ANY PRESCRIPTION MEDICATIONS FOR WEIGHT LOSS? (CIRCLE) YES NO**

- If yes, medication (circle) Phentermine, Diethylpropion, Xenical, Phendimetrazine, Meridia, Belviq, Qsymia, Contrave, other: __________________________

  - Did you lose weight with this medication? (circle) YES NO
  - Did you experience any side effects on this medication? (circle) YES NO

  If yes, please explain: ________________________________________________________

**ARE YOU INTERESTED IN MEAL REPLACEMENTS (I.E. SHAKES/BARS)? (CIRCLE) YES NO**

**DO YOU HAVE ANY DIETARY RESTRICTIONS? (CIRCLE) YES NO**

- Avoid Dairy __________________________
- Avoid Beef __________________________
- Avoid Pork __________________________
- Gluten Free __________________________
- Vegetarian __________________________
- Pescaterian (Vegetarian, however will eat fish) __________________________
- Lacto-Ovo Vegetarian (will eat eggs and dairy) __________________________
- Ovo Vegetarian (will eat eggs, no dairy) __________________________
- Lacto Vegetarian (will eat dairy, no eggs) __________________________
- Vegan (no foods derived from animals) __________________________
- Other __________________________

**DO YOU HAVE ANY FOOD ALLERGIES? (CIRCLE) YES NO**

- If yes, what food(s) __________________________

  - What type of reaction do you have? __________________________________________
  - Do you have an epi-pen? __________________________________

**DO YOU HAVE ANY FOOD SENSITIVITIES? (CIRCLE) YES NO**

- If yes, what food(s) __________________________

  - What type of reaction do you have? __________________________________________

**DO YOU HAVE ANY SENSITIVITIES TO GLUTEN, LACTOSE, ARTIFICIAL SWEETENERS? (CIRCLE) YES NO**

- If yes, explain: ____________________________________________________________

**HOW MANY TIMES PER WEEK DO YOU EAT AT RESTAURANTS OR TAKE-OUT MEALS?**

**WHAT TYPE OF RESTAURANTS DO YOU FREQUENT?**

- Fast Food __________________________
- Sit – Down / Chain __________________________
- Pubs __________________________
- Deli __________________________
- Fine Dining __________________________

**DO YOU SKIP MEALS? (CIRCLE) YES NO**

**DO YOU EAT BREAKFAST DAILY? (CIRCLE) YES NO**

**WHO LIVES WITH YOU?**

**DO YOU HAVE SUPPORT AT HOME TO MAKE LIFESTYLE CHANGES? (CIRCLE) YES NO**

**WHO PREPARES THE MEALS IN YOUR HOME?**

**WHO DOES THE GROCERY SHOPPING?**

**ARE YOU COMFORTABLE READING FOOD LABELS? (CIRCLE) YES NO**

**ARE YOU COMFORTABLE MEASURING PORTIONS? (CIRCLE) YES NO**

**HAVE YOU EVER KEPT A FOOD DIARY? (CIRCLE) YES NO**

- If yes, on paper __________________________
- On computer __________________________
- On phone app __________________________
- Other: __________________________

**DO YOU EAT AT A KITCHEN OR DINING ROOM TABLE? (CIRCLE) YES NO**

**DO YOU WATCH TV WHILE YOU EAT? (CIRCLE) YES NO**

**DO YOU DRINK SODA? (CIRCLE) YES NO**

- If yes, diet or regular? __________________________
- How much soda/day? __________________________
DO YOU DRINK SWEETENED BEVERAGES? (CIRCLE) YES NO
☐ If yes, what type and how often

DO YOU DRINK CAFFEINE? (CIRCLE) YES NO
☐ If yes, what type and how much

HOW MUCH WATER DO YOU DRINK DAILY? ____________________________

FOOD DIARY – Typical Day

**** Very important that you complete for your Initial Appointment ****

<table>
<thead>
<tr>
<th>Breakfast</th>
<th></th>
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<tbody>
<tr>
<td>Snack</td>
<td></td>
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<tr>
<td>Lunch</td>
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<tr>
<td>Snack</td>
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<tr>
<td>Dinner</td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
</tr>
</tbody>
</table>

DO YOU EAT DESSERTS? (CIRCLE) YES NO
☐ If yes, what type?
☐ How often?

SUBSTANCE USE

DO YOU DRINK ALCOHOL? (CIRCLE) YES NO
☐ If yes, how much and how often?
☐ How many beverages per week?

DO YOU SMOKE CIGARETTES? (CIRCLE) YES NO

HAVE YOU QUIT SMOKING IN THE PAST 6 MONTHS? (CIRCLE) YES NO

DO YOU HAVE ANY HISTORY OF ADDICTION? (CIRCLE) YES NO
☐ If yes, explain (including gambling/ shopping/ alcohol/ substance/ sugar, etc.)

DISORDERED EATING

DO YOU EAT FOR REASONS OTHER THAN HUNGER? (CIRCLE) YES NO
☐ If yes, explain:

DO YOU HAVE ANY CURRENT DISORDERED EATING? (CIRCLE) YES NO

DO YOU HAVE ANY PAST ISSUES WITH DISORDERED EATING? (CIRCLE) YES NO

IF YES TO EITHER CURRENT OR PAST, PLEASE INDICATE:
☐ Anorexia
☐ Bulimia
☐ Binge Eating
☐ Emotional Eating
☐ Stress Eating
☐ Overeating
☐ Night Eating
☐ Other:

MOOD:

DO YOU HAVE A HISTORY OF MOOD DISORDERS? (CIRCLE) YES NO
☐ Anxiety
☐ Depression
☐ Panic Attacks
☐ Bipolar Disorder
☐ Anger
☐ Irritability
☐ Other

PLEASE INDICATE YOUR LEVEL OF STRESS ON A SCALE OF 1 TO 10 (0 = NO STRESS, 10 = VERY STRESSED) : ___________

SLEEP

DO YOU STOP BREATHING AT NIGHT? (CIRCLE) YES NO

DO YOU FEEL TIRED IN THE MORNING? (CIRCLE) YES NO

DO YOU SNORE? (CIRCLE) YES NO

DO YOU WORK A NIGHT SHIFT OR SWING SHIFT? (CIRCLE) YES NO
HOW MANY HOURS OF SLEEP DO YOU GET NIGHTLY (OR DAILY)? NO
HAVE YOU EVER HAD A SLEEP STUDY? (CIRCLE) YES NO

OCCUPATION
Do you work outside of the home? (Circle) YES NO
☐ Homemaker:
☐ Student:
☐ Occupation:
☐ Retired from:
☐ Disabled:
☐ Other:

HOW MANY HOURS PER WEEK DO YOU WORK? ______________________

IS YOUR JOB STRESSFUL? (CIRCLE) YES NO

EXERCISE and ACTIVITY
Please indicate the level of activity that your job requires:
☐ Sedentary
☐ Light Activity
☐ Moderate Activity
☐ Heavy Labor

DO YOU EXERCISE? (CIRCLE) YES NO
☐ If yes, how many days per week? __________________________________________________
☐ What do you do for exercise? ______________________________________________________
☐ How long have you been exercising regularly? _______________________________________

If you exercise, please indicate the intensity of your exercise
☐ Light (you could sing)
☐ Moderate (you can speak in complete sentences)
☐ Vigorous (you are only able speak a few words)
☐ Intervals of moderate and vigorous

WHAT EXERCISES DO YOU ENJOY?

DO YOU HAVE ANY LIMITATIONS TO EXERCISE?
☐ Injury
☐ Motivation
☐ Health
☐ Access
☐ Time

DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE (HEART ATTACK, BYPASS SURGERY, STENTS, ANGIOPLASTY, CORONARY DISEASE, SUDDEN DEATH, CARDIOMYOPATHY, OTHER)? (CIRCLE) YES NO
☐ If yes, explain: _________________________________________________________________

DO YOU HAVE A FAMILY HISTORY OF PREMATURE HEART DISEASE? (WOMEN UNDER THE AGE OF 65, MEN UNDER THE AGE OF 55)? (CIRCLE) YES NO
☐ If yes, explain: _________________________________________________________________

DO YOU EXPERIENCE ANY OF THE FOLLOWING: (IF YES, EXPLAIN)
☐ Chest pain :
☐ Dizziness :
☐ Fainting :
☐ Shortness of Breath :

HAVE YOU EVER HAD AN EKG? (CIRCLE) YES NO
☐ If yes, when and where? ________________________________________________________

HAVE YOU EVER HAD A STRESS TEST? (CIRCLE) YES NO
☐ If yes, when and where? ________________________________________________________

HAVE YOU EVER HAD AN ECHOCARDIOGRAM? (CIRCLE) YES NO
☐ If yes, when and where? ________________________________________________________

Thank you for taking the time to complete this questionnaire. This information will help us prepare for your initial appointment.
INITIAL VISIT NO SHOW / CANCELLATION POLICY:

INITIAL VISITS CAN LAST 1 ½ -2 HOURS. DUE TO THE LARGE AMOUNT OF TIME AND LIMITED NUMBER OF THESE VISITS, THERE WILL BE A $100.00 CHARGE FOR PATIENTS THAT DO NOT CALL TO CANCEL OR RESCHEDULE THEIR APPOINTMENTS WITHIN A MINIMUM OF 48 HOURS PRIOR TO THEIR VISITS.

THIS ALLOWS US TIME TO CALL OTHER PATIENTS THAT ARE ON OUR WAITING LIST FOR OUR PROGRAM TO COME IN FOR THEIR INITIAL VISIT.

CONSIDERATION WILL BE GIVEN TO SAME DAY CANCELLATIONS BASED ON WEATHER CONDITIONS.

WE CARE MANAGEMENT
WAIVER OF LIABILITY AND INFORMED CONSENT RELEASE

This release, Waiver of Liability and Informed Consent Release and Agreement, is made by and between the undersigned participant, _______________ (participant name) and Community Care Physicians, P.C., We Care, Dr. Katherine Stam and whomever they designate as their assistants (hereinafter “CCP”) in connection with certain fitness and/or wellness programs to be provided by CCP including, but not limited to Zumba Classes, general Pilates Training, Yoga, Ball Pilates, Mat Pilates, Ballistic Abs, Personal Training, and other Group fitness classes.

I have agreed to participate in a program of physical exercise with CCP at the We Care location. I acknowledge that my present and subsequent participation is purely voluntary and in no way mandated by CCP. I recognize that the program requires physical exertion that may be strenuous at times and may cause physical injury and I am fully aware of the risk and hazards involved. This exercise program may include cardiovascular conditioning, muscle strengthening, endurance, and flexibility work. The possible benefits include: weight loss, improving cardiovascular fitness, muscle strength, endurance, proper body posture and alignment.

I understand that this is my responsibility to consult with a physician prior and regarding my participation in the above mentioned program. I represent and warrant that I have no medical condition that would prevent my participation in the program. In the event that a medical clearance must be obtained prior to my participation in the program, I agree to consult my physician and obtain written permission in order to participate in this exercise program. I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform my trainer and doctor of my symptoms.

I further represent that I am in good health and physical condition and that I am not disabled in any way, taking medication or suffering from any condition that would prevent me from safely engaging in such activities or that would make such participation potentially dangerous or harmful for me. I affirmatively assert that should I become disabled, begin taking medication or acquire any medical condition that could cause such participation to be dangerous or harmful to me, I will notify CCP immediately, and cease all participation immediately. Should this occur, I agree that I will not return to participation in such potentially harmful activity without clearance from my physician.

I agree to assume full responsibility for any risks, injuries or damages known or unknown which I might incur as a result of participating in this program. The possibility of certain unusual changes during exercise exists. They include such conditions as muscle soreness/stiffness, abnormal blood pressure, fainting, disorders of heartbeat, and instances of heart attack and death. I hereby acknowledge and accept these risks.

I recognize that Community Care Physicians, P.C. specifically disclaims any liability for any participant’s individual use or application of information or techniques provided by CCP. Therefore, in consideration of my participation in this program, I, hereby release CCP and its agents from any claims, demands, and causes of action as a result of my voluntary participation and enrollment.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the program have been answered to my satisfaction.

I waive, indemnify, exonerate, hold harmless CCP for any claims, demands and causes of action (including attorney’s fees) arising out of or pertaining to any loss, damage, injury or death sustained, caused by any negligent act or act of omission or my participation in a session with CCP or breach of duty related to CCP. This release applies whether or not any claim, demand, action or suite is based upon, or alleged to be based on or in part, the negligent act or act of omission or similar conduct of those parties are hereby released and indemnified. I hereby acknowledge that I possess adequate medical and hospitalization insurance coverage in case of injury. I further acknowledge that I might have the right to choose what exercises I do or do not perform in addition to withdrawing from any exercise at any time.

I acknowledge that I have carefully read this consent and fully understand that it is a release of all liability. In addition, I do hereby waive any right that I may have to bring a legal action or assert a claim for injury or loss of any kind against me for my negligence or arising out of or relating to participation by me in any of the activities or use of the equipment, facilities or services provided to me by CCP.

Signature of participant
Print name: ____________________________ DOB: ____________________________
Signature: ____________________________ Date: ____________________________
Witness signature
Print name: ____________________________
Signature: ____________________________ Date: ____________________________

Katherine Stam, DO • 713 Troy-Schenectady Road, Suite 215 Latham, NY 12110 • Phone: (518)713-5347 • Fax: (518) 713-5359
I ____________________________ authorize Community Care Physicians, P.C., We Care, Dr. Katherine Stam and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs not supervised by a physician.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions, whatsoever, concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Signature of patient or patient representative

Print name: ____________________________  DOB: ______________

Signature: ____________________________

Date: ______________

Witness signature

Print name: ____________________________

Signature: ____________________________

Date: ______________