Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

RIGHTS & CONSENT TO TREATMENT

- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Personal Health Information (PHI) will be maintained in a secure, locked environment. Electronic records are maintained with a secure, dual firewall system called InSync. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someoneelse from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions typically run for 38-52 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand and give my consent to the use of Blueprint, a HIPAA-compliant web and mobile platform that helps me and my provider measure progress throughout treatment and make adjustments to treatment as needed.
- ❑ I understand and consent to the use of Recovery Record Service, a HIPAA-compliant web and mobile platform for eating disorder education and management to record and evaluate recovery goals and progress.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and dietitians actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cellphones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the practice manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws.Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature_____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature_____ **Date** _____

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,_____, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form, you are agreeing to let us use your information and send it to others under the circumstances described in ourNotice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore, our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kaitlyn Patterson, LPA at kaitlyn.patterson@chrysaliscenter-nc.com or at the contact information listed above.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Assistant Clinical Director at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree tothese limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Assistant Clinical Director telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understood its content, and agree toits stipulations.

Signature:_____ Date: _____

Printed Name:_____ Date of Birth: _____

Relationship to Client (if guardian or representative):

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

□ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

□ ***Client Refuses to Acknowledge Receipt****:*

Signature of authorized representative of this office or practice: _____

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OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS: All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late, you will be asked to reschedule your appointment, which will result in a late cancellation charge.

RECORDING DEVICES: The use of recording devices by clients, clinicians, and other persons present during a session, group or other clinical interaction, whether face-to-face or taking place by live textual, audio, or video link is strictly prohibited. Administrative calls may be monitored for quality assurance.

BLUEPRINT: Blueprint respects the privacy of all users and will never sell any personally identifiable data. You own your data at all times and can always request your data and account to be deleted by sending an email to support@blueprint-health.com with the subject of "Account Deletion." You can view Blueprint's privacy policy in detail at www.blueprint-health.com/privacy. Measuring your progress through Blueprint may be considered a billable service by your provider towards your insurance plan and as a result may result in additional co-payments, amounts applied to deductibles, and other amounts that may be deemed the responsibility of the patient as required by contract with the insurance plan and state regulations.

PAYMENT: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment taken, credits and debits will be applied to the card immediately. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder: _____ Billing Zip code: _____

Expiration Date: _____ CVV/CVC: _____

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $90 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminders are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE: As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.

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Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file.

Please note: Treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued. If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do notreimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____I have read, understand, and agree to the above policies.

_____I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_____I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

_____I have been offered a copy of these policies to take with me if I desire.

_____I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service

_____I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed:_____

_____ _____

Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

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Communications Policy

Contacting Providers

When you need to contact your provider for non-emergent situations, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (910-790-9500). Our clinicians do not have direct voicemails, but you can leave a message or leave a confidential voicemail with our administrative staff.
- If you wish to communicate by email, please discuss further with your clinician. Please review the Rights and Consents about the potential confidentiality risks of doing so

Please refrain from making contact with any member of your treatment team using social media messaging systems. Any communication through social media is strictly prohibited as it can create significant security risks for clients.

Please refrain from contacting you provider using SMS (normal phone text messages).

Your provider may utilize HIPAA-compliant mobile and web platforms (e.g., Blueprint, Recovery Record) to support therapeutic goals and measure treatment progress.

- These services are HIPAA-compliant to keep patient information secure even when shared with treatment teams.
- These platforms do not give medical, legal, or psychological advice, diagnoses, or treatment. These services may provide helpful Health-Related Information, but are not intended to substitute for professional advice, diagnoses, treatment, or your judgment.
- Under no circumstances should these services be used to report emergencies to your providers. Chrysalis providers will not be monitoring these services at all times.

Confidentiality is vital to therapy. Please speak with your provider about any concerns you have regarding preferred communication methods.

Response Time

Our office is open Monday-Thursday 8:30am-5pm and Fridays 8:30am-4pm. Our administrative and clinical staff may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within *48 hours* (weekends are excepted from this timeframe). It is likely you will receive a reply more quickly than that, but please be aware that this will not always be possible.

Be aware that there may be times when your clinician may be unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call the local police by calling 911 or go to your nearest emergency department. Possible locations include:

New Hanover Regional Medical Center
910-343-7000
2131 17th St.
Wilmington, NC 28401

Cape Fear Hospital
910-452-8100
5301 Wrightsville Ave.
Wilmington, NC 28403

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Following your call to 911 or your visit to your nearest emergency department, if you need to reach your provider, the best methods of communication are:

- By the main office line: 910-790-9500
- If you cannot reach someone by phone, please leave a voicemail

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others. While we take precautions whenever possible to ensure the confidentiality of communication through these methods, we cannot always guarantee your confidentiality. Use of these modes of communication implies your understanding and consent to this limitation of confidentiality. Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I have read and understood this document and will address any concerns or questions with my therapist and/or the practice manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime.

Client/Representative Signature _____ Date_____

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**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, andthe following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

_____Please initial if you do not want to use your insurance benefits; you will be chargedthe self-pay rate for services.

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Relationship to Policy Holder:_____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is myresponsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature

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CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential. ***If you do not complete these forms in their entirety prior to your first appointment, you will not be able to see any provider at Chrysalis Center.***

This is a very long form, please take your time and take breaks . Many patients are concerned that if they answer honestly this could negatively affect their chances for approval. Please be assured your answers provide points of discussion for your strengths and challenges in the upcoming weight loss journey. Everyone has both and we seek to help you find yours.

Demographic Information:

Name: _____ SSN: _____ Date: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Which phone is the best way to contact you? _____ Is it okay to leave a message? Yes No

Date of Birth: _____ Age: _____ Gender: _____

Ethnic Group _____ Religious Preference: _____

Relationship Status: _____Single _____ Cohabitating _____ Married

_____ Separated _____ Divorced _____ Widowed

Emergency Contact: _____ Telephone: (____) _____

Relationship to you: _____

Referral/Clinical Information:

How did you find out about our services? _____

I currently live with: (Check all that apply)

_____ Alone _____ With significant other/partner _____ With parents/guardians

_____ With Children _____ With other relatives _____ With roommates

Please indicate the total number of persons living in your home: _____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

Education Information:

Highest Level of Education Completed: Grade School High School College Graduate School

Are you currently a student? Yes No

If yes, where? _____ Year: _____ Major: _____

Health Information:

Primary Care Physician: _____

Date of Last Physical: _____

Please list any chronic illnesses, injuries, physical conditions or disabilities:_____

_____

_____

Allergies/Adverse Reactions to Treatment:_____

_____

Symptoms/Medical Conditions:

Which of the following are you currently experiencing/have you been diagnosed with?

_____ Loss of period	_____ Chest pain	_____ Ulcers
_____ Infertility	_____ Irregular period	_____ Anemia
_____ Nausea	_____ Acid reflux/GERD	_____ Dizziness
_____ Shortness of breath	_____ Diabetes	_____ Tingling
_____ Frequent urination	_____ Hypoglycemia	_____ Numbness
_____Irregular heartbeat	_____ Dehydration	_____ High cholesterol
_____ Fatigue	_____ Water retention	_____ Hypertension
_____ Trouble sleeping	_____ Excessive thirst	_____ Joint pain
_____ Gas	_____ Swelling of ankles	_____ Cardiac issues
_____ Cramps	_____ Swelling of hands	_____ Sleep apnea
_____ Bloating	_____ Headaches/migraines	_____ Constipation
_____ Diarrhea	_____ Excessive sweating	

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

Family/Significant Others:

Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Relationship to You	Age	Place of Residence	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

Mental Health History:

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.
_____ Quite well, no significant complaints.
_____ Fairly well, but have ups and down.
_____ So-so, can keep going with effort.
_____ Quite poorly, can barely manage.
_____ Very poorly, can't manage.

Have you experienced the following symptoms:	Ever?	Recently?
Depressed mood	yes/no	yes/no
Irritability	yes/no	yes/no
Guilt	yes/no	yes/no
Extreme Mood Swings	yes/no	yes/no
Rapid Speech	yes/no	yes/no

Have you experienced the following symptoms:	Ever?	Recently?
Extreme Anxiety	yes/no	yes/no
Social Anxiety	yes/no	yes/no
Panic Attacks	yes/no	yes/no
Phobias/Fears	yes/no	yes/no
Sleep Disturbances	yes/no	yes/no
Hallucinations	yes/no	yes/no
Attention/Concentration Difficulties	yes/no	yes/no
Unexplained Memory Lapses	yes/no	yes/no
Alcohol/Substance Abuse	yes/no	yes/no
Frequent Body Complaints	yes/no	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no	yes/no
Flashbacks	yes/no	yes/no
Feelings of Dread/Something bad will happen to you or loved one	yes/no	yes/no
Following Strict Routines/Rigid Rules	yes/no	yes/no

Have any of these symptoms ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain.

_____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain.

_____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates.

_____

_____

Have you received counseling before? Yes No

If yes, when, where, and with whom? _____

_____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify) _____

_____ Physical Abuse

_____ Sexual Abuse/Molestation

_____ Verbal/Emotional Abuse

_____ Sexual Assault

Please circle if you are currently experiencing any greater than usual stress in your life related to the following events.

a. Work
b. Health
c. Relationship with significant other
d. Activities related to children
e. Activities related to parents
f. Legal/financial trouble
g. School
h. Moving
i. Other _____

Substance Use: Which of the following substances do you use? Specify amount and frequency.

	Past	Current	Type, amount & frequency
Alcohol	_____	_____	_____
Illicit Substances	_____	_____	_____
Cigarettes/Vaping	_____	_____	_____
Caffeine	_____	_____	_____
Soda	_____	_____	_____

Weight History:

Current Height:_____ Current Weight: _____ Desired Weight: _____

Lowest Weight: _____ Date/age of this weight _____

Highest Weight: _____ Date/age of this weight_____

How often do you weigh yourself? _____

When did you first have a problem with weight? (childhood, adolescence, pregnancy, etc.)

_____

Please circle behaviors that are problematic for you:

Overeating at breakfast
Overeating at lunch
Overeating at dinner
Grazing between meals
Snacking after dinner
Eating because I crave certain foods
Inability to feel full
Eating because I can't stop once I've begun
Eating in the middle of the night
Grazing while cooking or preparing food
Eating when anxious
Eating when tired or bored
Eating when depressed or upset
Eating when stressed or angry
Eating when socializing or celebrating
Eating when alone
Eating with family or friends
Eating at business functions

Food History:

Daily Intake: Please answer the following with respect to what you ate PRIOR to starting any dietary changes in anticipation of Weight Loss Surgery or on any short term diet plan.

How many meals or snacks do you eat in a typical day? _____

Do you tend to plan your meals and snacks? ____ Yes ____ No

Are your portion sizes typically small, medium, or large? _____

Please give examples of a typical day's intake :

Breakfast: _____

Midmorning Snack: _____

Lunch: _____

Afternoon Snack: _____

Dinner: _____

Evening Snack:_____

Are there specific times/situations you are more likely to eat larger portions?

_____

What do you typically drink during a day? (Circle all that apply)

Skim milk	____ times per week	Fruit juice	____ times per week
Low fat milk	____ times per week	Water	____ times per week
Whole milk	____ times per week	Sugar-free drinks	____ times per week
Energy drinks	____ times per week	Sports drinks	____ times per week
Tea (Sweet)	____ times per week	Soda	____ times per week

How many times do you eat :

At a fast food establishment (including drive thru, convenience stores) ____ times per week/month

At restaurants	____ times per week/month
Take out/Door Dash	____ times per week/month
Dessert	____ times per week/month

Diet History :

Please list any diets you have tried over the years, such as: Weight Watchers, Keto, Atkins, Jenny Craig, Nutrisystem, Paleo, Prescribed and OTC Medication.

Diet Program	*How long did you follow this plan?*	*How much weight did you lose, if any?*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Restrictive Eating

Have you engaged in:

	Past	Current		Past	Current
Skipping Meals	_____	_____	Fasting	_____	_____
Reducing Portions	_____	_____	Reducing Calories	_____	_____
Restricting Carbs	_____	_____	Restricting Fats	_____	_____
Restricting Proteins	_____	_____	Restricting Dairy	_____	_____
Chewing & Spitting	_____	_____	Throwing Away Food	_____	_____

Current Exercise Program

Activity Type:

____ Stretching	____ times per week/month
____ Cardio/Aerobics	____ times per week/month
____ Strength Training	____ times per week/month
____ Walking	____ times per week/month
_____ Other	____ times per week/month

Rate your level of motivation for exercise, please circle: Low Medium High

List problems that limit activity:

_____

_____

_____

Which of the following do you do **more than 2 times per week**?

____ Eat while driving	____ Eat in your bed
____ Eat while at your computer or on your phone	____ Eat standing up
____ Finish a portion of food and didn't realize you ate it	____ Eat in front of the TV

	Past	Currently
Eating so much in a short amount of time to the point of making yourself feel sick	yes/no	yes/no
Feeling out of control while eating	yes/no	yes/no
Feeling that your eating is/was excessive and /or not really normal	yes/no	yes/no
Feeling depressed, ashamed or disgusted after eating	yes/no	yes/no
Hiding Food/Eating Alone	yes/no	yes/no
Using food to calm yourself	yes/no	yes/no
Eating in response to stress/negative emotions	yes/no	yes/no

	Past	Currently
Using laxatives, diuretics, or vomiting to control weight	yes/no	yes/no
Nighttime Eating	yes/no	yes/no
Feeling that you are not hungry when you wake in the morning	yes/no	yes/no
Consuming the majority of your calories after dinner	yes/no	yes/no
Waking up in the middle of the night to eat	yes/no	yes/no

Weight Loss Surgery Preparation:

How long have you been thinking about having weight loss surgery?

_____

What has prompted you to want to pursue surgery now?

_____

Have you decided which surgery is best for you?

_____

Who knows about your decision to pursue surgery?

_____

Listed below are a few common reasons people want to have surgery. Please rate by importance.

	Not at all	Slightly	Moderately	Considerably	Extremely	N/A
Increase mobility						
Increase energy						
Resume/adopt new activities						
Improve social life						
Enhance occupational functioning						
Improve health						
Prevent future health problems						
Increase life expectancy						
Decrease pain						
Feel better						
Improve appearance						
Improve self-esteem						
Improve sex life						
Improve relationship w/ significant other						
Practical reasons/Quality of life						
Other (describe):						

If you are currently involved in a supportive relationship (spouse, significant other, friend, relative, etc.) please answer these questions:

What is this person's attitude toward your efforts to lose weight? (check one)

____ Strongly supports my efforts
____ Supports my efforts
____ Neutral
____ Opposes my efforts
____ Strongly opposes my efforts

Are you planning any major life changes (e.g. new job, moving, relationship, etc.) during the next 6 months?
____ Yes ____ No

If yes, please briefly describe below:

_____

How stressful do you think your life will be in the next 6 months excluding your efforts to lose weight? Pick a number between 1-5; 1 = much less stressful than normal and 5 = much more stressful than normal.

_____

How confident you are that you will be able to significantly change your eating and exercise habits? Pick a number between 1-10; 1 = not confident and 10 = extremely confident.

_____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

CONSENT TO TESTING & CONTRACT FOR BARIATRIC SURGERY EVALUATION

- ☐ I am aware that a pre-operative psychological evaluation is required. This evaluation will consist of extended clinical interviews and psychological assessment. Due to the extensive nature of the evaluation, 2 or more office visits may be required to complete the process.
- ☐ I consent to take part in testing for the purpose of accurate diagnosis and treatment planning. I understand that it is in my best interest to actively participate in testing and to follow the treatment recommendations that result.
- ☐ I understand that it is extremely important that I am completely honest with my evaluator so that she can make an informed decision and provide me with the optimal level of care as I go through this process. I understand that my evaluator wants to ensure my success with surgery.
  I agree to read each test item carefully and answer honestly. Try to avoid over-thinking items, as it is best to go with your initial response to each question. Honesty is of utmost importance, as some forms of testing can detect dishonest and/or defensive responding. It is possible that your test results will not be able to be used if you attempt to portray yourself in an overly positive way. Realize that it is normal and expected for people to report problems. If your test results are found to be invalid, that may interfere with our ability to make a decision regarding appropriate treatment or, if applicable, to make recommendations for surgery.
- ☐ I understand that I have the right to refuse or discontinue testing at any time. However, doing so could impede effective diagnosis and treatment planning.
- ☐ I understand that my psychological evaluation report will be released to my doctor and to my insurance company for further review, and that they will ultimately determine whether or not I am approved for surgery.
- ☐ I understand that my clinician and surgeon will be sharing treatment recommendations. I am aware that the result of this evaluation is a recommendation regarding my appropriateness for surgery and the level of support I may need in order to optimize my success with the surgery.
- ☐ I understand that neither raw test data nor the psychological report will be released directly to me. I am aware that if I desire feedback or an interpretation of my testing, I will need to schedule an additional session with the clinician who performed the evaluation.
- ☐ I understand that there is no guarantee that any particular outcome will result from testing.
- ☐ I understand that there is a fee for comprehensive testing and evaluation and that I am responsible for the cost for the evaluation. The evaluation includes a clinical interview, psychological testing, interpretation of the test, collaboration with other providers, and preparation of the psychological report. The cost of the clinical interviews will be determined when scheduling an initial appointment, based on insurance coverage. I understand that there is an administrative fee of $150 ($75 for the test, $75 for report and related services explained above). I understand that my insurance company will not be billed for this service as psychological testing because the medically-necessary components of this service extend beyond the definition of those allowable codes. I understand that payment in full is expected at the time of the initial appointment. If full payment is not received, the psychological report will not be submitted to the surgeon until payment is remitted.
- ☐ I am aware that ongoing group counseling, nutritional counseling, and therapy are available to me following my surgery for additional support. The cost for is determined by your insurance coverage.
- ☐ **I understand that raw test data may be used in outcomes research by Chrysalis Center and that I have the right to refuse to participate in such research. No identifiable data will be used in any of our research.**

□ Check if you refuse to participate in this research, knowing this will not affect outcomes in any way.

If you have any questions or concerns, please address them with your evaluator and/or the office manager before signing this. **My signature indicates that I understand and agree to all of the above.**

Client/Representative Signature: _____ Date _____

Print Name: _____ Date: _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Staff Signature _____ Date _____

