Patient Intake Form

Patient Name: (Last) _____ (First) _____(MI)_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Birthdate: _____ Age: _____ Sex: M F

Email: _____

Employment Information:

Patient Employer: _____Occupation:_____

City: _____ State: _____ Zip:_____

Work Phone No: _____Ext:_____

In Case of Emergency:

Name: _____ Relationship_____ Phone_____

Patients Spouse: _____ Phone _____

Family Physician: _____ Phone_____

How Did You Hear About Us? (*Please circle or identify where necessary)

Direct Mail Radio Friend Brochure Internet

If referred, by whom:

Financial Policy:

Thank you for selecting Physicians Center for Weight Loss and Age Management for your health care needs. This is to inform you of our billing requirements and our financial policy. Please be advised that payments for all services will be due at the time of services are rendered, unless prior arrangements have been made. For your convenience, we accept visa, Master Card, Discover, American Express, and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all I have read and understand all of the above I have read and understand all collection costs, attorney's fees and court costs.

I have read and understand all the above and have agreed to these statements.

X_____ _____

Patient signature Date

Patient Medical History Form

Patient Name: _____ Age: ____ DOB: ___/___/____ Sex: M/F

1. Are you in good health at the present time to the best of your knowledge? Yes/ No
   Explain a "NO" answer:

_____

2. Are you under a doctor's care at the present time? Yes/No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes/No

List all Prescription Drugs

1._____
2. _____
3. _____
4. _____

List all over-the-counter Medications, Vitamins

1. _____
2_____
3. _____
4. _____

Are you allergic to any medication? : Yes / No

If yes please list:

_____

Personal Health History Questionnaire

(CIRCLE ALL THAT APPLY)

Eyes:	Glaucoma double vision eye diseases Glasses contacts
Ear/Nose/throat	tinnitus (ears ringing) nose bleeding hoarsness
Cardiovascular disease:	chest pain heart failure murmur vascular disease fainting lower extremity edema coronary artery disease stroke heart disease irregular pulse(palpitations/flutter) rheumatic fever blood clots
Respiratory disease	shortness of breath asthma bronchitis pneumonia seasonal allergies hay fever Chronic cough
Gastrointestinal disease	gallbladder gall stones diarrhea constipation bloody stools liver disease Stomach ulcers indigestion nausea / vomiting
Genitourinary disease	kidney or bladder disorder BPH/prostate enlargement overactive bladder
Other	diabetes high blood pressure high cholesterol sleep apnea thyroid disease Anemia fatigue migraine head ache
Musculoskeletal	arthritis/ joint problems osteoporosis back pain
Psych	Anxiety depression memory loss trouble sleeping drug/alcohol abuse
Cancer	breast ovarian prostate colon other_____

Family History (circle all that apply to anyone in your immediate family)

High blood pressure heart disease stroke diabetes atherosclerosis (hardening of the arteries)
Thyroid disease high cholesterol osteoporosis or bone disease
Cancer (list type of cancer_____

Surgical History: List your previous surgeries

1. _____ 3. _____
2. _____ 4. _____

Gyn History [women]

Menstruation began at age _____. 28 day cycle Y/N Are your periods regular Y/N Are your periods painful Y/N

GU History [men]

Date of last prostate or rectal exam_____
Has force of your urination decreased Y/N
Have you had blood in your urine Y/N
Do you have problems emptying your bladder Y/N

Social History

Do you exercise Y / N If yes how often?

_____

Alcohol: Y / N If yes how much?

_____

Tobacco Y / N If yes how much?

_____

Primary Care Physician (PCP) _____Date of last physical exam: _____

Weight Loss Program Questionnaire

When did you first become overweight?

_____

How long have you been trying to lose weight?

_____

How did your weight gain start? Describe any circumstances

_____

Your present weight_____lb Goal weight _____lb

Circle ALL PROGRAMS THAT YOU HAVE TRIED IN ORDER TO LOSE WEIGHT

Weight Watchers Overeaters Anonymous NutriSystems Jenny Craig Obesity Surgery OTC Diet Pills

Other: _____

Have you ever taken prescription weight loss medication (appetite suppressants)? Yes / No

If yes, name of program: _____

Name of appetite suppressant: _____

Did you have any side effects? Y / N If yes, list side effects? _____

Check any of the dietary problem areas listed below that apply to you:

( ) Meal skipping	( ) Carbohydrate Craving	( ) Large Portion Size
( ) Too Much Alcohol	( ) Eating foods too high in fat	( ) Frequent Snacking
( ) Eating too many meals out	( ) Eating before going to bed	( ) Eating when not hungry

PATIENT RECORD of DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of individuals home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____ ☐ Written Communication _____

☐ O.K. to leave message with detailed information ☐ O.K. to mail to my home address

☐ Leave message with call back number only ☐ O.K. to mail to my work/office address

☐ O.K. to fax to this number

☐ Work Telephone _____ ☐ Other _____

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

_____ _____

Patient's Signature Date

_____ _____

Print Name Date

I have received or reviewed both pages of HIPPA privacy practice notice and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy statement.

Patient Signature: _____ Date: _____

Informed Consent for Prescription of Weight Loss Enhancers

Pregnancy

The appetite suppressants prescribed by the **Physicians Center for Weight Loss & Age Management** are Pregnancy Category C Drugs. This means **there is uncertain safety in pregnancy.** Even though *no human studies* have been performed, animal studies show an adverse effect. Therefore, Physicians Center for Weight Loss &Age Management highly recommends that you use some type of contraception to prevent pregnancy **DURING** and **FOR ONE MONTH AFTER** you are on the appetite suppressants.

Nursing Lactation

The appetite suppressant prescribed by **Physicians Center for Weight Loss & Age Management,** are also **"generally regarded as unsafe during lactation".** Therefore, Physicians Center for Weight Loss & Age Management recommends that you **DO NOT BREASTFEED** while you are on the appetite suppressants.

By signing this form, I acknowledge the receipt of the above information. 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, or any questions have not been answered to my complete satisfaction.

I, _____

Signature _____ Date _____

Weight Loss Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss more than one and a half to two pounds per week or weight loss more than one percent of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address, and qualifications of the dietician or nutritionist who has reviewed and approved the weight loss program according to s. 468-55(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes.

I have read the above:

PRINT NAME: _____

Patients Signature: _____ DATE _____

PATIENT CONSENT AND DISCLOSURE FORM FOR MEDICAL WEIGHT LOSS MANAGEMENT

Patient's Name: _____- Date: _____

1. I hereby request and authorize Physician Center for Weight Loss &Age Management to perform the evaluation and treatment for participation in the weight management program. The goal of this weight management program is to perform a personalized weight loss regimen combining nutrition education, exercise, and when appropriate nutritional supplementation and appetite suppressant medications. I understand that my results may be may not be perfect.
2. Each patient case is different, and the results and length of treatment will vary among individuals.
3. I understand that although there are many health benefits to weight loss there also may be significant risks and complications associated with rapid weight loss, exercise and pharmaceutical agents. I have discussed my overall health and participation in the weight management program with my physician and I am willing to accept all of these risks, including death. I have discussed my concerns and questions with both my primary care physician and Physicians Center for Weight Loss & Age Management have had them all answered to my satisfaction
4. I understand that the prescription medications used have an action similar to amphetamines which may include central nervous system stimulation and elevation of blood pressure. They are indicated as a short- term adjunct in a regimen of weight reduction based on exercise, behavioral modifications, and calorie restriction.
5. I understand that these drugs may be habit forming and will need to be tapered slowly upon cessation.
6. I understand that there is a lack of scientific data relating to the dangers of long term use of medicine.
7. I understand that the following are contraindications to the use of Phentermine and Phendimetrazine:
    a. Severe hypertension (high blood pressure)
    b. Severe arteriosclerosis (hardening of the arteries) or heart disease
    c. Hyperthyroidism
    d. Glaucoma
    e. Pregnancy or nursing mothers
    f. Allergy to this medication
    g. History of drug abuse

Concomitant use of guanethidine or if you have taken furazolidone or MAO inhibitor (eg, phenelzinewith the last 14 days
8. I understand that some medicines may interact with the Phentermine and that I must notify Physicians Center for Weight Loss & Age Management if I am taking the following medications:
    a. Anti-Depressants SSRI or TRAMODOL because of risk of high blood pressure, tremors, seizures, or irregular heartbeat may increase
9. I understand that the following side effects or complications from Phentermine may happen to me:

    a. Dry mouth, constipation, or diarrhea
    b. Nervousness
    c. Insomnia
    d. Headache
    e. Elevation of blood pressure
    f. Shortness of breath
    g. Tachycardia or rapid heartbeat
    h. Hives
    i. Dizziness, Syncope or fainting
    j. Primary Pulmonary Hypertension (PPH)
    k. Valvular heart disease

10. I understand that the weight loss medication is not to be shared with anyone.
11. I understand that lost medication will not be refilled any earlier than anticipated
12. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the treatment. I also understand that the goal of this treatment is improvement, not perfection.
13. I agree to keep Physicians Center for Weight Loss & Age Management informed of any change of address so that the doctor can notify me of any new reports of late complications from this type of treatment, and I agree to be cooperative with Physicians Center for Weight Loss & Age Management in my care until completely discharged.
14. I understand that I have the right to request an itemized statement of my costs
15. I have read the above consent and fully understand the nature of this treatment and the risks involved. I acknowledge and understand that no expressed or implied warranty has been given to me. I have been given an opportunity to ask questions about the condition to be treated, the alternative forms of treatment, including no treatment at all, the procedures to be used, and the risks and hazards involved. All questions have been answered satisfactory and I believe that I have sufficient information to give this informed consent. I certify that this form is been fully explained to me, that I have read it or have had it read to me, that the blank spaces have either been filled or crossed off, and that I understand its contents.
16. I understand that if Physicians Center for Weight Loss & Age Management judges at any time that my treatment should be postponed or cancelled for any reason he/she may do so.
17. I understand that I have the right to consult my pharmacist concerning the availability of a less expensive generically equivalent drug and the requirements of Florida law.
18. I understand that treatment with weight loss medication is on a short-term basis only.
19. I understand that the medicine given may lose its effectiveness over time.
20. I understand that any successful weight loss program must involve diet, exercise, and life style changes.
21. I understand to maintain weight loss, diet and exercise must be continued part of my lifestyle.
22. I understand that there is a possibility of bruising, redness at the site of injection or at the site of the blood draw.
23. I hereby state that the information furnished to Physicians Center for Weight Loss & Age Management during my comprehensive evaluation is correct and that I have disclosed all known medical conditions, allergies or adverse reactions to medical preparations.
24. I agree to follow instructions given to me by Physicians Center for Weight Loss & Age Management to the best of my ability before, during and after the treatment, and that I will, as soon as possible, notify Physicians Center for Weight Loss & Age Management of any questions and conditions that may arise.

_____	_____	_____
Patient Signature	Print Name	Date

Physician signature: _____ Date: _____

Patient Authorization

I, _____Date of Birth_____
Hereby authorize Physicians Center for Weight Loss & Age Management and/or its staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancelations and tender payments on my behalf.

NAME: _____

NAME: _____

PATIENT'S SIGNATURE: _____
Patient needs to sign this consent form even if they do not authorize.

Photograph Consent Form

I, _____
Hereby authorize___ /do not authorize___ Physicians Center for Weight Loss & Age Management, staff to take my photograph during my initial consultation and at the end of my weight loss program. I understand that these pictures are FOR OFFICE PURPOSES ONLY, and ARE KEPT IN MY CHART AT ALL TIMES.

PATIENT'S SIGNATURE _____DATE_____

WITNESS: _____DATE_____

Patients Requirements

We require that our patients commit to weekly evaluations. All weight management clinical studies show that this is a key ingredient to your success.

This is also to inform you that the medications dispensed to you during your weight loss program are FDA-approved appetite suppressants. They are controlled substances and as such are highly regulated by state and federal agencies. We undergo periodic evaluations by the Florida Department of Health to assure compliance with these laws.

The physician will see you at each visit and will evaluate your progress. The physician will always see you if there is a problem. Medication is reviewed at each visit, according to the statutes. We appreciate your patience if there is a slight delay during the checkout process.
The success of your weight loss program can be limited if you decide to take this medication in any way other than prescribed. We assume that you will keep us updated on any changes in your medications or health status each visit.

The sharing of these medications is absolutely forbidden and could be extremely dangerous. These medications can have severe side effects if certain medical conditions are present.
Thank you for your cooperation!
Patients Signature: _____ Date: _____