TLC MEDICAL WEIGHT LOSS, PLLC

Patient Information Form

Personal Information:

Patient Name: (Last) ______________________ (First) ______________________ (MI) ________

Name you prefer to be called: ______________________

Patient Address: ______________________

City: ______________________ State: __________ Zip ______________________

Home Phone: ______________________ Cell: ______________________

Birthdate: ______________________ Age __________ Sex: M F SS# ________-________-________

Country of Birth: ______________________ Country of Parents' Birth: ______________________

How did you hear about us? ______________________ Referred by ______________________

E-mail Address: ______________________

Employment Information:

Patient Employer : ______________________ Occupation: ______________________

Employer Address: ______________________

City: ______________________ State: __________ Zip: ______________________

Work Phone No: ______________________ Ext: ______ Driver's License # ______________________

In Case of Emergency:

Name: ______________________ Relationship: ______________ Phone: ______________

Patient's Spouse: ______________________ Phone: ______________________

Family Physician: ______________________ Phone: ______________________

Financial Policy:

Thank you for selecting TLC MEDICAL WEIGHT LOSS, PLLC for your weight loss needs. We are honored to be of service to you and your family. This is to inform you of your billing requirements and our financial policy. Please be advised that payment for all services will be due at time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, and Discover.

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

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

Patient signature: ______________________ Date: ______________________

TLC MEDICAL WEIGHT LOSS, PLLC

Patient Informed Consent for Appetite Suppressants

Procedures and Alternatives:

I. I, ___________________________________(patient or patient's guardian), authorize Charisse Soller, APRN, CNS-BC and Cynthia Hodgins, APRN, FNP-C to assist me in my weight reduction efforts. I understand my treatment my involve, but not limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

II. I have read and understand mu provider's statement that follow:
"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated on the labeling."

"As a bariatric provider, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied s that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects" (as noted below).

"As a bariatric provider, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

III. I understand it is my responsibility to follow the instructions carefully and to report, to the provider treating me for my weight, any significant medical problems, that I think may be related to my weight control program, as soon as reasonably possible.

IV. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

No Guarantees:

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 I will have to continue watching my weight all of my life if I am to be successful.

Patient's Consent:

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 if any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO 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.

Patient's Signature: ___________________________ Date: _________________

Witness' Signature: ___________________________ Date: _________________

Provider's Declaration:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient had been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above. A medication handout has been provided to the patient with extensive information about the prescription appetite suppressants and my recommendation for use of them.

Provider's Signature: _____________________________ Date: _______________

TLC MEDICAL WEIGHT LOSS, PLLC

WEIGHT LOSS CONSUMER BILL OF RIGHTS

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have the 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, supplements, services, examinations and laboratory tests), and/or know the actual or estimated duration of the program.

I have read the above:

Patient's Signature: ______________________________ Date: ______________________________

HCG PROGRAM ACKNOWLEDGEMENT

If I choose to so the HCG program, I am aware that it is not FDA approved for weight loss and very few studies have been done to validate its effectiveness for fat metabolism.

Patient's Signature: ______________________________ Date: _________________________

TLC MEDICAL WEIGHT LOSS CLINICS, PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

All patients have the right to have confidential care provided. All information, Medical or Social, whether written, spoken, electronic or computer generated, is to be held in strict confidence.

By signing below you acknowledge receipt or availability of receipt of the TLC Medical Weight Loss Clinics, PLLC Notice of Privacy Practice. This notice explains how TLC Medical Weight Loss Clinics, PLLC may use and disclose your protected health information for treatment, payment and health care operation purposes. "Protected Health Information" means your personal health information found in your medical and billing records. TLC Medical Weight Loss Clinics, PLLC reserves the right to change the notice from time to time. A copy of the current notice or a summary of the current notice is posted at patient service locations throughout TLC Medical Weight Loss Clinics, PLLC. The effective date of the notice appears on the first page of the notice or summary. In addition, True Weight Loss Clinic has available for you at your request, a copy of the current notice in effect.

Your signature below acknowledges that you are aware that there is a privacy notice located in the clinic available for you. That your have been offered a copy of the privacy notice and have received or declined said copy.

Patient Signature: ______________________________ **Date:** ______________

Witness Signature: ______________________________ **Date:** ______________

Patient Name: ______________________________

DOB: ____________________

TLC MEDICAL WEIGHT LOSS LLC

General- ☐ **NONE**

- ☐ Weight loss or gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Trouble sleeping

Head- ☐ **NONE**

- ☐ Headache
- ☐ Head injury

Ears- ☐ **NONE**

- ☐ Decreased hearing
- ☐ Ringing in the ears (tinnitus)
- ☐ Earache
- ☐ Drainage

Eyes- ☐ **NONE**

- ☐ Vision
- ☐ Glasses or contacts
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Glaucoma
- ☐ Last eye exam
- ☐ Pain
- ☐ Redness
- ☐ Cataracts
- ☐ Specks

Neck- ☐ **NONE**

- ☐ Lumps
- ☐ Pain
- ☐ Swollen glands
- ☐ Stiffness

Respiratory- ☐ **NONE**

- ☐ Cough (dry or wet, productive)
- ☐ Shortness of breath (dyspnea)
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular- ☐ **NONE**

- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitation
- ☐ Shortness of breath with activity (dyspnea)
- ☐ Swelling in feet or hands (edema)
- ☐ Difficulty breathing lying down (orthopnea)

Gastrointestinal- ☐ **NONE**

- ☐ Swallowing difficulties
- ☐ Change in appetite
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Yellow eyes or skin (jaundice)
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea

Vascular- ☐ **NONE**

- ☐ Calf pain with walking (Claudication)
- ☐ Leg cramping

Musculoskeletal- ☐ **NONE**

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic- ☐ **NONE**

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness
- ☐ Fainting
- ☐ Weakness
- ☐ Tingling
- ☐ Tremor

Endocrine- ☐ **NONE**

- ☐ Head or cold intolerance
- ☐ Frequent urination (polyuria)
- ☐ Thirst (polydysia)
- ☐ Change in appetite (polyphagia)
- ☐ Sweating

Psychiatric- ☐ **NONE**

- ☐ Nervousness
- ☐ Memory loss
- ☐ Depression
- ☐ Stress
- ☐ Anxiety

Date of latest EKG ___________________

Date of Latest Echocardiogram _______________

<u>PATIENTS</u> PLEASE FILL THIS OUT TO LET US KNOW IF YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS.

Patients Name: ____________________________________

DOB: _______________ Date: _________________

TLC MEDICAL WEIGHT LOSS, PLLC

PATIENTS: Please initial besides each statement that you DO NOT have these conditions

_____I DO NOT currently have hyperthyroidism

_____I DO NOT currently have and never have been treated for glaucoma (a condition of increases pressure in the eyes)

_____I DO NOT currently have and never have been treated for heart/cardiovascular disease

_____I AM NOT taking MAOI inhibitors (an old type of antidepressant) NOR have I taken them in the past 14 days

_____I DO NOT currently have or have NOT ever had arteriosclerosis (hardening of the arteries)

_____I DO NOT currently have and have never been treated for moderate or severe hypertension (high blood pressure)

_____I DO NOT currently have and have NEVER been treated for anxiety disorder or agitation, bipolar disorder

_____I DO NOT currently have or have NEVER been in treatment for nor do I have a history of drug abuse

_____I AM NOT currently pregnant nor do I plan to become pregnant while under medical treatment at TLC MEDICAL WEIGHT LOSS, PLLC and I am taking precautions to not get pregnant at this time

_____I am currently NOT breastfeeding

_____I AM NOT currently taking any other prescription appetite suppressant or diet medication

Patient Signature: ______________________________ Date: ______________________

Witness: ____________________________________ Date: ______________________

TLC MEDICAL WEIGHT LOSS CLINICS, PLLC

PATIENT HISTORY

PRESENT HEALTH STATUS:

CURRENT AGE ________

PRESENT WEIGHT ________ HEIGHT ________ DESIRED WT? ________

1. Are you in good health at the present time (to the best of your knowledge)? ______ YES ______ NO
2. Do you see a medical provider regularly? ______ YES ______ NO
3. MEDICATIONS YOU ARE CURRENLY TAKING. (prescriptions and over the counter)

DRUG	DOSAGE

4. Are you allergic to any medications? ______ YES ______ NO

DRUG

____

____

____

FAMILY MEDICAL HISTORY

____ALCOHOL ABUSE	____DIABETES	____EATING DISORDERS
____HEART DISEASE	____HYPERTENSION	____KIDNEY DISEASE
____LIVER DISEASE	____OBESITY	____PSYCHIATRIC ILLNESS
____THYROID DISORDER		

PERSONAL MEDICAL HISTORY

____ALCOHOL ABUSE	____EATING DISORDER	____HISTORY OF DRUG ABUSE
____ANXIETY DISORDER	____GALLBLADDER DISORDER	____HYPERTENSION
____ARTHRITIS	____GERD (heartburn)	____KIDNEY DISEASE
____DIABETES	____HEADACHES/MIGRAINES	____LIVER DISEASE
____ TYPE 1	____HEART DISEASE	____THYROID DISORDER
____ TYPE 2 ONSET AGE ______	____HIGH CHOLESTEROL	____OTHER

5. Number of pregancies/children ______ AGES ________________
6. Current birth control method: ________________

TLC MEDICAL WEIGHT LOSS CLINICS, PLLC

NUTRITIONAL EVALUATION

DESIRED WEIGHT __________ WEIGHT ONE YEAR AGO ______________

MAXIMUM LIFETIME WEIGHT (NON PREGNANT) ____________

LOWEST WEIGHT AFTER AGE 18 ___________

1. WAS THERE A SPECIFIC TIME IN YOUR LIFE WHEN YOU GAINED WT? ______________________
2. WHAT IS THE REASON YOU THINK YOU ARE OVERWEIGHT OR UNABLE TO LOSE WEIGHT? __________________

____

PREVIOUS DIETS YOU HAVE TRIED:

	DIET:	Year/ When	How long on that diet?	Amount of weight lost?	How long did you keep that weight off?
1					
2					
3					
4					
5					

3. IS YOUR SPOUSE/PARTNER OVERWEIGHT? _____ YES _____ NO
4. DO YOU CRAVE CERTAIN FOODS? _____ YES _____ NO
5. IS THERE A TIME YOU START TO CRAVE? WHAT TIME? ______________________
6. WHAT FOODS DO YOU CRAVE ? ______________________
7. WHAT ARE YOUR WORST FOOD HABITS ? _____ ______________________
8. WHO PLANS MEALS AT HOME? ____________ SHOPS? __________ COOKS? ___________

TYPICAL BREAKFAST ______________________________

TIME EATEN ______________

TYPICAL LUNCH ______________________________

TIME EATEN ______________

TYPICAL DINNER ______________________________

TIME EATEN ______________

SNACK HABITS: (DO YOU SNACK/WHAT DO YOU SNACK ON)? ______________________

____

HOW MUCH? _____SMALL AMOUNT _____MODERATE AMOUNT

_____LARGE AMOUNT _____GRAZING FROM _______ TO _________

WHAT TIME (S)? ______________________________

TLC MEDICAL WEIGHT LOSS CLINICS, PLLC

ACTIVITY LEVEL

1. _____INACTIVE - NO REGULAR EXERCISE WITH A SIT DOWN JOB
2. _____LIGHT ACTIVITY - NO ORGANIZED PHYSICAL ACTIVITY DURING LEASURE TIME
3. _____MODERATE ACTIVITY - ACCASIONALLY INVOLVED IN ACTIVITIES SUCH AS WEEK-END GOLF, TENNIS, JOGGING, SWIMMING OR CYCLING
4. _____HEAVY ACTIVITY - CONSISTENT LIFTING, STAIR CLIMBING, HEAVY CONSTRUCTION REGULAR PARTICIPATION IN JOGGING, SWIMMING, CYCLING, OR ACTIVE SPORTS AT LEAST 3 TIMES PER WEEK
5. _____VIGOROUS ACTIVITY - EXTENSIVE PHYSICAL ACTIVITY AT LEAST 60 MIN PER SESSION 4 TIMES PER WEEK

REASONS WHY YOU WANT TO LOSE WEIGHT:

1 ____

2 ____

3 ____

4 ____

5 ____

6 ____

7 ____

8 ____

9 ____

10 ____