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 Cell: _____Cell: _____

Birthdate: _____ Age: _____ Sex: M F

Country of Birth: _____ Country of Parents' Birth: _____

How did you hear about us? _____ Referral by: _____

E-mail Address: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No.: _____ Ext: _____

In case of Emergency:

Name: _____ Relationship: _____ Phone No.: _____

Patient's Spouse: _____ Phone No.: _____

Family Physician: _____ Phone No.: _____

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 arrangement 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 or attorney for collection, I will be responsible for all collection cost, attorney's fees and court costs.

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

Patient Signature: _____ Date: _____

TLC MEDICAL WEIGHT LOSS, PLLC

PATIENT INFORMED CONSENT FOR OFF LABEL USE OF APPETITE SUPPRESSANTS

TREATMENTS AND ALTERNATIVES:

I. I, _____ (patient), authorize the medical providers at TLC Weight Loss, to assist me in my weight reduction efforts. I understand treatment may involve, but is 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. **PATIENT INITIALS**_____

II. I have read and understand our 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 dosage indicated on the labeling." **PATIENT INITIALS**_____

"As bariatric providers, we have found the appetite suppressants helpful for periods in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As providers, we are not required to use the medication as the labeling suggests, but we use the labeling as a source of information along with our own experience, the experience of our colleagues, recent longer term studies and recommendations of university based investigators. Based on these, we 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 as the suggested labeling and it is possible, as with most other medications, that there could be serious side effects" (as noted below). **PATIENT INITALS**_____

"As bariatric providers, we believe the probability of such side effect 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."

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 our weight control program, as soon as reasonably possible. **PATIENT INITIALS** _____

VERY IMPORTANT: I understand that losing weight may alter my hormones and I may become pregnant even if I have had difficulty conceiving in the past. I understand that if I do not wish to become pregnant it is my responsibility to prevent pregnancy.

PATIENT INITIALS _____

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 our continuing to receive the appetite suppressant will be dependent on our progress in weight reduction and weight maintenance. **PATIENT INITIALS**_____

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. **PATIENT INITIALS _____**

Risks of Proposed Treatment:

I understand this authorization is given with knowledge that 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, and 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. **PATIENT INITIALS _____**

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 significantly the more overweight I am.

PATIENT INITALS _____

No Guarantees:

I understand that much of the success of the program will depend on our 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 our weight all of our life if I am to be successful. **PATIENT INITIALS _____**

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 our complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with our doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. **PATIENT INITIALS _____**

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 PROVIDER BEFORE SIGNING THIS CONSENT FORM.** **PATIENT INITIALS _____**

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

Provider's Declaration:

We have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of our knowledge, we 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 our recommendation for use of them.

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 of more than 1% of body weight per week after the second week of participation in a weight loss program. Qualifications of the provider are available upon request. You have the right to: ask questions about the potential health risk 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 test), and/ or know the actual or estimated duration of the program.

I have read the above:

Patient's signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE 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 Clinic, PLLC Notice of Privacy Practices. This notice explains how TLC Medical Weight Loss Clinic, PLLC may use and disclose your protected health information for treatment, and health care operation purpose. "Protected Health Information" means your personal health information found in your medical records. TLC Medical Weight Loss Clinic, PLLC reserves the right to change the notice from time to time. A copy or summary of the current notice is held in a binder in each clinic and is available to you at your request.

Your signature below acknowledges that you are aware that there is a privacy notice located in the clinic and available to you.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

REVIEW OF SYSTEMS

General- NONE

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

Head- NONE

- ☐ Headaches
- ☐ Head injury

Ear- NONE

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

Eye- NONE

- ☐ Vision
- ☐ Glasses or contacts
- ☐ Blurry or double vision
- ☐ Flash light
- ☐ Glaucoma

Neck- None

- ☐ Lump
- ☐ Pain

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)
- ☐ Difficult 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
- ☐ Trauma

Neurologic- NONE

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness

Endocrine- NONE

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

Psychiatric- NONE

- ☐ Nervousness
- ☐ Memory Loss
- ☐ Depression

Date of latest EKG _____

Date of latest Echocardiogram _____

***PATIENT PLEASE FILL THIS OUT TO LET US KNOW IF YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS**

TLC MEDICAL WEIGHT LOSS, PLLC

PATIENT: Please initial beside 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 inhibitor (an old type of antidepressant) NOR have I taken them in the past 14 days

_____ I DO NOT Currently have and never had arteriosclerosis (hardening of the arteries)

_____ I DO NOT Currently have and have never 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 and 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

_____ **VERY IMPORTANT:** I understand that losing weight may alter my hormones and I may become pregnant even if I have had difficulty conceiving in the past. I understand that if I do not wish to become pregnant it is my responsibility to prevent pregnancy.

_____ I AM NOT currently taking any other prescriptions appetite suppressant or diet medication

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT MEDICAL AND DIET HISTORY

Present Health Status

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 currently taking. (prescription & over the counter)

Drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. **PERSONAL MEDICAL HISTORY**

_____ High Blood Pressure _____ Diabetes: (Type 1 _____ Type 2 _____) _____ Abnormal Blood Sugar _____ High Cholesterol _____ Thyroid Disorder: (_____ Low _____ High_____)

Current Birth Control Method _____

5. **FAMILY MEDICAL HISTORY**

_____ Diabetes _____ High Blood Pressure _____ Heart Disease _____ Thyroid Disorder

6. **DIETS YOU HAVE TRIED:**

_____ What year _____
_____ What year _____
_____ What year _____

7. What are your favorite food? _____
   _____
8. Do you snack? _____ Yes _____ No
9. What do you snack on? _____