Prescription Weight Loss, INC

I,_____ understand this diet program requires a medical exam each and every appointment by the treating physcian. If ever upon exam I'm found not medically suitable for the program, I agree to pay the fee of one hundred dollars for that days visit.

PATIENT INFORMATION
PRESCRIPTION WEIGHT LOSS INC.

Full Name:_____
Date of Birth:_____

Are you allergic to any medications? (**Circle**) *Yes* or *No* (If yes, please list)

_____

Are you allergic to any vitamins? (**Circle**) *Yes* or *No* (If yes, please list)

_____

PERSONAL HISTORY (Answers Required)
(**Circle**) *Yes* or *No*

Alcoholism	*Yes* or *No*
Angina Pectoris (Chest Pain after Exercise)	*Yes* or *No*
Cysts of breast or ovaries	*Yes* or *No*
Diabetes	*Yes* or *No*
Epilepsy	*Yes* or *No*
Heart Disease	*Yes* or *No*
Hypertension (High Blood Pressure)	*Yes* or *No*
Migraine Headaches	*Yes* or *No*
Psychiatric Illness (nervous Problem)	*Yes* or *No*
Substance Abuse	*Yes* or *No*
Thyroid Disease	*Yes* or *No*

When was your last menstrual cycle? _____
Do you have any reason to believe your pregnant? (**Circle**) *Yes* or *No*

_____

Have you ever taken an appetite suppressant?
(**Circle**) *Yes* or *No* (If yes, please list)

_____

Are you currently taking any type of medications including oral contraceptives?
(**Circle**) *Yes* or *No* (If yes, please list medication and dosage)

_____

The questions above have been answered truthfully to the best of my knowledge.

Patients Signature:_____
Date:_____

INITIAL EVALUATION
PRESCRIPTION WEIGHT LOSS INC.

1. How long have you had a weight problem?_____

2. Have you tried any other procedures for weight loss? **Circle** *YES* or *NO* (If yes please list)

_____

_____

3. How long were you on the program? _____

_____

4. Are you currently on ANY diet plans? **Circle** *YES* or *NO* (If yes please list)

_____

_____

5. Have you experimented with any weight loss diets, exercise, or substances within the past year? **Circle** *YES* or *NO* (If yes please list)_____

_____

_____

6. Are you currently taking any diet medication whether it being controlled or over the counter? **Circle** *YES* or *NO* (If yes please list) _____

_____

_____

7. Have you ever been hospitalized for drug abuse? **Circle** *YES* or *NO* (If yes when?)

_____

_____

_____

PATIENTS SIGNATURE _____

DATE_____

CONSENT FOR MEDICAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires Prescription Weight Loss Inc. to obtain your consent to our contemplated medical procedure. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your medical procedure and the risks associated, and that we have answered all of your questions in a satisfactory manner. Please read the form carefully. If you do not understand any portion of this form please ask an employee for a thorough explanation.

1. I hereby authorize and direct **Prescription Weight Loss Inc.,** with assistants of his choice, to perform upon _____
(Name of Patient)
the following **medical weight loss** procedures.

2. In general terms, one part of the **Prescription Weight Loss Inc.** Program is administration of **medication** to assist in weightloss.

3. Some side effects known to be associated with adminstration of the medications are:
   1) Restlessness
   2) Palpitations
   3) Hyperactivity
   4) Nausea and Dryness of mouth
   5) Headache

These certain side effects occur in less than 5% of patients and commonly occur during the first week.

I have been informed of the probability of occurrence of each of the foregoing risks as the results of or in connection with the medical procedure.

I hereby state that I have read and understand this consent. All questions about the procedure or procedures have been answered in a satisfactory manner, and all blanks were filled in prior to my signature. This consent is valid until revoked by me in writing.

CONSENT FORM

SIGNATURE OF PATIENT_____

DATE:_____TIME:_____A.M./P.M.

I certify that all blanks in this form were filled in prior to my signature and I explained them to the patient.

HIPPA NOTICE OF PRIVACY PRACTICES

PRESCRIPTION WEIGHT LOSS INC.

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Who Will Follow This Notice?

All Prescription Weight Loss INC. Staff

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this notice, we describe the ways that we may use and disclose health information about you. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies an individual or where there is a reasonable basis to believe the information can be used to identify an individual. This information is called "Protected Health Information" (PHI). This notice describes your rights and our obligations regarding the use and disclosure of PHI.

We are required by law to:

- Make sure that your health information is kept private.
- Give you this notice of our legal duties and privacy practices with respect to your personal information.
- Follow the terms of the notice that is currently in effect.
- Train our personnel concerning privacy and confidentiality; and
- Mitigate (Lessen the harm of) any breach of privacy/confidentiality.

How We May Use and Disclose Health Information About You:

The following categories describe the different ways we may use and disclose personal health information. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Complaints: If you are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may write to the Secretary of Health and Hospitals.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may disclose your protected health information from time-to-time to other nurses, technicians, health students, physician, or health care provider (for example, a specialist, pharmacist, or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Right to Change Terms of this Notice: We may change the terms of this Notice at any time. If we change this notice, we may make the new notice terms effective for all protected health Information that we maintain including any information created or received prior to issuing the new notice. You may obtain a copy of any corrected notices upon request.

Right to an Accounting of Disclosures: You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices.

(Patient's Name Printed) DATE

Witness (OPTIONAL) DATE

PREGNANCY WAIVER FORM

As a routine part of our practice, all women of childbearing age are solely responsible to know if they are pregnant or know the last date of their menstrual period. There are risk with taking any appetite suppressant. By signing below you are releasing PRESCRIPTION WEIGHT LOSS, INC to prescribe a medication to you without performing a pregnancy test.
If unsure a pregnancy test is recommended prior to one starting any appetite suppressant.

Patient Name_____
Please Print

Patient Signature_____

Date of Birth_____/_____/_____

Date_____/_____/_____

Health Care Operations: We are permitted to use and disclose your personal health information for our business operations. These uses and disclosures are necessary to run Prescription Weight Loss INC. and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We also my remove all information that identifies you from a set of PHI so that others may use that information to study health care and health care delivery without learning who the specific patients are.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including, for example, claims audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

Required By Law: We may use and disclose PHI as required by federal, state or local law. Any disclosure must comply with the law and is limited to the requirements of the law.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal processes when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Research: We may disclose your protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

To Avert a Serious Threat to Health or Safety: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can be made only to a person who is able to help prevent the threat.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you.

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations.

Right to Amend: You have the right to request that we amend personal health information about you as long as such information is kept by or for our office. Amendments may be denied in certain cases, including if the information is accurate and complete. You have the right to obtain copies of your health information at the cost of $.25 per page.

Weight Loss Clinic Questions

1. Do you suffer from high blood pressure?

2. Do you have glaucoma? (high pressure inside your eye)

3. Do you have any heart valve problems or right sided heart problems? (pulmonary hypertension)

4. Do you have raynaud's syndrome, lupus or other vascular problems?

5. Are you taking oral contraceptives or any hormones? (thyroid medication)

6. Have you ever had a blood clot in your legs or lungs? (pulmonary embolus)

DOB _____ Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (Cell) _____

Height _____

Email Address: _____

How did you hear about us? (Check One)

❒ Public ❒ Radio ❒ Friend ❒ Phone Book

❒ Bill Boards ❒ Newspapers ❒ Signs ❒ Other _____