ACHIEVE
MEDICAL
WEIGHT LOSS

Patient Basic Information Form
(to be filled out by patient)

Your Name: Last_____First_____M.I.____

Name you prefer to be called: _____

Your Address: Street_____Apt/Suite #_____

City:_____State:_____Zip Code:_____

Home Phone (Including Area Code):_____Cell:_____

Birth date:_____Current Age:_____ Sex: M F

Your e-mail address:_____Referred by:_____

How did you hear about us? (please check all that apply)

___Radio ___Mail-out ___Internet ___Saw a Sign ___Television

___Newspaper ___Word of Mouth ___Movie ___Facebook ___Other_____

ALLERGY INFORMATION

Are you allergic to Sulfa type medications? Yes No

EMERGENCY CONTACTS
(AT LEAST 2 OTHER PEOPLE)

Name:_____Relationship_____Phone_____

Name:_____Relationship_____Phone_____

Physician:_____Phone_____

FINANCIAL POLICY

Thank you for selecting Achieve Medical Weight Loss for your health care. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept Visa, MasterCard, Discover, Checks and Cash. I have read and understand all of the above and have agreed to these statements.

Patient's (or Guardian's) Signature:_____Date:_____

PATIENT MEDICAL HISTORY

Full Name:_____DOB:_____ Sex: M F

PRESENT HEALTH STATUS:

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. List all Prescription Drugs
Drug_____Dosage_____ Drug_____Dosage_____
Drug_____Dosage_____ Drug_____Dosage_____
List all Over-the-Counter Drugs Drug_____Dosage_____
Drug_____Dosage_____ Drug_____Dosage_____
Drug_____Dosage_____ Drug_____Dosage_____

4. Any allergies to any medications? Yes No
   Please List:

5. History of High Blood Pressure? Yes No
6. History of Heart Attack or Chest Pain or other Heart condition? Yes No
7. History of Glaucoma? Yes No
8. History of Bi-Polar Illness? Yes No
9. History of Hyperlipidemia/High Cholesterol? Yes No

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

____Anemia ____Kidney Disease ____Over-active ____Heart Disease
____Drug Abuse ____Bleeding Disorder ____Thyroid Disease ____Alcohol Abuse
____Eating Disorder ____Heart Valve Disorder ____Liver Disease

FAMILY HISTORY: Has any blood relative ever had any of the following?

Heart Disease/Stroke: Yes No Who:_____
How old were they when they had it?_____
Epilepsy: Yes No Who:_____
High Blood Pressure: Yes No Who:_____
Diabetes: Yes No Who:_____
Psychiatric Disorder: Yes No Who:_____

NUTRITIONAL AND LIFESTYLE EVALUATION

1. What is your main reason for losing weight?_____
2. Desired weight?_____
3. Weight at 20 years old?_____Weight one year ago?_____
4. When did you begin gaining excess weight? (give reasons, if known)_____

_____

5. Is your spouse, fiancee or partner overweight? (circle one) Yes No
6. How often per week do you eat out?_____Times per week you eat "fast food"?_____
7. How many times a day do you eat?_____

   Breakfast YES or NO What time?_____ What does it consist of?_____

   Lunch YES or NO What time?_____ What does it consist of?_____

   Dinner YES or NO What time?_____ What does it consist of?_____
8. How many snacks do you get daily?_____

   What type of snacks do you eat?_____
9. Foods you are allergic to: _____
10. Foods you crave:_____
11. Do you drink coffee, soda or tea? Yes No How Much daily?_____
12. Do you wake up hungry during the night? Yes No How often?_____
13. Previous diets you have followed: list description (or name) and your results (use back)

_____

14. Do you drink alcohol (circle one)? No Occasionally Weekly Daily

    If yes, circle all that you drink: Beer Wine Distilled Spirits
15. Smoking Habits (choose only one)

_____ You have never smoked cigarettes, cigars or a pipe

_____ You have quit smoking_____years ago and have not smoked since

If so, how long did you smoke before you quit?_____

_____ You smoke: How many packs per day_____

16. Activity Level (choose only one)

_____ Inactive: no regular physical activity with a sit-down job.

_____ Light: no organized physical activity during leisure time.

_____ Moderate: occasionally such as golf, tennis, jogging, swimming, cycling, etc.

17. Briefly describe what weight control and activity/exercise program you are currently on

_____

18. Any over the counter supplements?_____

– – – – – – – –DO NOT FILL IN BELOW THIS LINE– – – – – – – –

Caloric intake plan

☐ 1000 NOTES:_____

☐ 1200 _____

☐ 1500 _____

☐ 1800 Handouts Given/Lifestyle Program?_____

☐ 2000 _____

☐ 2500 Sign_____Date_____

Patient Informed Consent For Appetite Suppressants

I. PROCEDURE AND ALTERNATIVES

1. I_____(patient or patient's guardian) authorize Dr._____and whomever he designates as his assistants to assist me in my weight reduction efforts. I understand my treatment may involve but not be 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. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instructions in behavior modification techniques, and may involve the use of appetite suppressant medications.
2. I have read and understand my doctor's statements 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 in the labeling.

"As a bariatric physician, 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 physician, 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 as the suggested in the labeling and it is possible, as with most other medications, there could be serious side effects (as noted below.)

"As a bariatric physician, 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."

3. I understand that a prescription monitoring report will be pulled upon my first visit.
4. I understand it is my responsibility to follow the instructions carefully and to report to the doctor 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.
5. 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.
6. 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.
7. I understand that while taking this medication, if I am required to have a drug screening it may affect the results.

(continued on next page)

Patient Informed Consent For Appetite Suppressants

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 suppressant.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than twelve 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 heart beat 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.

III. 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.

IV. No Guarantee:

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.

V. Fee Notice:

I acknowledge that I have received notice of the fact that Achieve has a business operations management agreement under which the management company is paid a percentage of gross income. To the extent that this could ever be construed as a division of fees for medical service, I acknowledge this relationship exist and consent to the division of any such fees.

VI. 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 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 THE CONSENT SIGNATURE FORM.

VII. Physician's Declaration

I have explained the contents of this document to the patient and have answered all the patient's related questions, 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.

_____

Physician's Signature/Nurse Practitioner's Signature Patient Initials_____

Patient Consent for Appetite Suppressants and Weight Loss Program

I have read and fully understand this consent form. I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding 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:_____ Date:_____
(or person with authority to consent for patient)

Witness:_____ Time:_____

HIPAA Privacy Notice

I have received a copy of the HIPPA privacy notice.

Signature:_____

Date:_____

Consent to Treatment

(WOMEN ONLY)

I understand that Phentermine and other anorectic medications should not be taken during pregnancy, due to the chance of damage to the fetus. The medications have been explained to me fully and I am aware of the risks involved.

To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both this clinic and my OB/GYN immediately.

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____

ACHIEVE MEDICAL WEIGHT LOSS

HIPAA Notice of Privacy Practices

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPAA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience. The full seven-page privacy notice is available here for you to read and you can ask for your own copy.

This Notice of Privacy Practices describes the ways we are allowed by law to use your protected health information (medical records) or PHI to carry out treatment, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes our rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your physician will use your PHI as he has always done for treatment, payment, or other health care operations. In addition we may also disclose your PHI from time to time to other physicians or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. Front desk sign in sheets will be used where you will be asked to sign your name and we will call you by name in the waiting room when your doctor is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us. There could include billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time, in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your physician will try to obtain your consent as soon as possible. Your PHI may be disclosed to public health agencies or law enforcement as needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain legal limitations. You may ask us not to disclose your PHI for purposes of treatment, payment or health care operations, as well as family members. This must be specific and in writing. However, your doctor is not required to agree to such restrictions if he believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know to whom we have revealed your information if it is other than for treatment, payment, or health care operations.