Patient Information Form

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

Patient Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Birthdate: _____ Age: _____ E-mail: _____

Are you currently covered under a Medicare/Medicaid policy? Yes No

Employment Information:

Patient Employer: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

In our continuing effort to respect your privacy and maintain the confidentiality of your care, please indicate in the space below how you want to be contacted. (Phone / home / cell / work / e-mail please explain).

AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENT'S CONDITION/TREATMENT

Dear Patient,
In accordance with the Medical Privacy Act of Texas, Our staff is unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care to someone other than yourself, please complete the following authorization.

I hereby authorize Physician's and/or staff of The M.D.'s Weight & Wellness Center, to release information pertaining to my condition and/or care to only those family members, physicians and/or others involved with my care as listed below:

Name	**Relationship**	**Telephone Number**
Name	**Relationship**	**Telephone Number**

_____ _____

Patient's Signature or Person with Authority to Consent for Patient **Date**

Medical History

Name:_____ Date of Birth:_____

Family Physician: _____ Phone: _____

Present Status:

At the present time what is the state of your health? Excellent Good Fair Poor
Are you under a doctor's care at the present time? Yes No

If yes, why? _____

Please list all medications and supplements which you are currently taking:

_____

_____

Please list all known allergies to medications, foods or other allergens: _____

_____

Medical History (circle all that apply)

High Blood Pressure	Measles	Tonsillitis
Diabetes	Mumps	Arthritis
Heart Disease	Scarlet Fever	Osteoporosis
Frequent Headaches	Whooping Cough	Alcohol Abuse
Migraines	Bleeding Disorder	Blood Transfusion
Glaucoma	Gout	Cancer
Edema/Swelling	Constipation	Pneumonia
Depression	Gallbladder Disease	Polio
Kidney Disease	Liver Disease	Drug Abuse
Lung Disease	Chicken Pox	Eating Disorder
Rheumatic Fever	Psychiatric Illness	Tuberculosis
Ulcers	Thyroid Disease	Other:_____
Anemia	Jaundice	_____

Ob/Gyn History: ***(Female Patients)***

Menstrual: Onset age: _____
Are they Regular? Yes No
Last menstrual Period? _____
Hormone Replacement Therapy Yes No
Current Method of Birth Control? _____ Last Pap Smear (date)_____

Pregnancies Yes No Number: _____ Dates: _____

Last Mammogram (date)_____

General Medical History

Date of last physical exam_____

Please list all current illnesses: _____

Please list all serious illnesses:_____

Please list all serious injuries: _____

Please list all surgeries:_____

Family History:

Current Age Health Disease (or cause of death) Overweight?

Father: _____
Mother: _____
Brothers: _____
Sisters: _____

Has any relative ever had any of the following?

Glaucoma	Yes	No	Who? _____
Asthma	Yes	No	Who? _____
Epilepsy	Yes	No	Who? _____
High Blood Pressure	Yes	No	Who? _____
Kidney Disease	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Tuberculosis	Yes	No	Who? _____
Psychiatric Disorder	Yes	No	Who? _____
Heart Disease/Stroke	Yes	No	Who? _____

Nutrition Evaluation:

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

Birth Weight: _____ Weight at 20 years of age? _____ Weight one year ago? _____

What is the main reason for your decision to lose weight? _____

_____

When did you begin gaining excess weight? (Give reasons, if known) _____

_____

Previous diets you have followed (give dates and results of your weight loss):

_____

_____

_____

Is your spouse, fiancée or partner overweight? Yes No

How often do you eat? _____

What restaurants do you frequent? _____

Who plans meals? _____ Cooks? _____ Shops? _____

Food you crave: _____

Any specific time of day or month you crave food? _____

Do you drink?

Coffee or Tea	Yes	No	How much daily? _____
Cola Drinks	Yes	No	How much daily? _____
Alcohol	Yes	No	Type_____Amt_____How Often_____

Do you use a sugar substitute? Yes No

Butter	Yes	No
Margarine	Yes	No

What are your worst food habits? _____

_____

_____

When you are under a stressful situation at work or family related, do you tend to eat more? Yes No
Explain: _____

_____

_____

_____

Are you currently experiencing a stressful situation or emotional upset? Yes No
Explain: _____

_____

_____

_____

Are you a smoker or have you ever been? Yes No (If you answered yes to either question, please list number of cigarettes per day, how long, and if no longer smoking when you stopped: _____

_____

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____

Describe your energy level: _____

Activity Level: (answer only one)

_____ Inactive- No regular physical activity with a sit down job
_____ Light Activity- No organized physical activity during leisure time.
_____ Moderate Activity- Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy Activity- Consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____ Vigorous Activity- participation in extensive physical exercises for at least 60 minutes per session.

Please describe any regular exercise in which you engage: _____

_____

Dr. Baker will review this information with you which will assist him in developing a safe and effective weight loss program individualized for you.

Weight Loss Program Consent Form

I _____ authorize Dr. Benton Baker III and whomever he may designate to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 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.

Date: _____ **Time:** _____

Patient: _____ **Witness:** _____

(Or person with authority to consent for patient)

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Dr. Benton Baker III 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.

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 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 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 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.

4. 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.

5. 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.

II. 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 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 significantly the more overweight I am.

IV. 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.

V. 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 THIS CONSENT FORM.

DATE: _____ TIME: _____

PATIENT: _____WITNESS: _____
(Or person with authority to consent for patient)

VI. PROVIDER 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 has 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.

_____

Provider's Signature

Appetite Suppressants Information

After careful evaluation of your medical history, physical examination, body analysis, other clinical findings and the development of realistic weight loss goals, Dr. Baker may determine that an appetite suppressant to reduce hunger is a reasonable therapeutic addition to your weight loss treatment plan. Dr. Baker will discuss the risks, alternatives, intended benefits, and potential side effects of these medications with you. The following information is provided to you for further understanding.

Each of the medications in this class (appetite suppressants) has effects that mimic the sympathetic nervous system. These may make you feel nervous, stressed or "hyper". As Dr. Baker explained to you, drugs such as **Phentermine, Phendimetrazine, Benzphetamine and Diethylproprion** are appetite suppressants and may therefore cause you to experience these sensations. Generally, these feelings are most pronounced during the first week or so of use and disappear or are greatly diminished shortly thereafter. They may also cause an increase in blood pressure and pulse rate. Small increases in blood pressure or pulse are acceptable but large elevations in either or both are not and should such occur, the dosage of the medication may be reduced or discontinued altogether.

Other common side effects of these medications can be dry mouth, constipation, irritability, and insomnia (difficulty sleeping). Dr. Baker will work with you to correct any of these should you experience them.

Although they are uncommon, should you experience severe side effects such as allergic reactions (hives, difficulty breathing, chest tightness, swelling of the face, mouth, or tongue), pounding in the chest, fainting, swelling of the legs or feet, or bizarre behavior seek medical attention at once!

When you fill your prescription at the pharmacy, you will be given more specific information concerning the drug prescribed. Carefully read everything you receive. It is also important that you inform Dr. Baker and your other health care providers of all medications, including any supplements you take, thereby allowing each of them to assist you in avoiding inappropriate combinations.

Should you have any questions or concerns, please never hesitate to contact The M.D.'s Weight & Wellness Center *(*936-756-8446).

Our primary goal is to improve your health!

M.D.'s Weight & Wellness Center

200 River Pointe Dr. Suite 115 Conroe, Texas 77304
Phone: 936-756-8446 Fax: 936-756-8472

Financial Policy

YOUR RESPONSIBILITY
You are financially responsible for all services we provide for you.

PRIVATE INSURANCE PATIENTS
The M.D.'s Weight & Wellness Center does **not** accept assignment for insurances. You will be required to pay all applicable fees at the time of service. Our office will provide you with a detailed receipt with all the necessary coding in order for you to file for reimbursement with your insurance company.

METHODS OF PAYMENT
We accept cash, check, Visa, MasterCard and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary by calling (936)756-8446.

RETURNED CHECKS
There will be a $40.00 fee assessed for any and all checks returned from the bank for any reason.

MISSED APPOINTMENTS AND NO SHOWS
We see patients on an appointment basis and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment. **A fee of $25.00 will be added to your account, every time proper notice is not given.**

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the doctor is responsible for payment, regardless of the terms of the custodial agreement.

INFORMATION CHANGE
Please advise us of any address or phone number changes promptly.

COLLECTION PROCEDURES
Members of our billing department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. All prior balances must be resolved before being seen by the physician.

I have read and understand the financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I hereby voluntarily consent to healthcare encompassing recommendations and treatment by my physicians, his/her associates, assistants or other healthcare providers, as may be necessary in my physician's judgment. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____
Signature of Patient or Guardian if a Minor Date

_____
Please print patient name

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply)

HOME TELEPHONE
□ OK to leave message on machine with detailed message
□ OK to leave message with call-back number only
□ OK to leave message with family member (Who? _____)

WORK TELEPHONE
□ OK to leave message on machine with detailed message
□ OK to leave message with call-back number only
□ OK to leave message with co-worker (Who? _____)

CELLULAR TELEPHONE
□ OK to leave message on voicemail with detailed message
□ OK to leave message with call-back number only

_____ _____
Signature of Patient or Guardian Date

_____ _____
Witness (Practice Representative) Date

The M.D.'s Weight & Wellness Center, PA
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This practice is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (Example)

"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Public Safety

It may necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefit purposes.

Appointment Reminders

As a courtesy to our patients, it is our policy to call you on the evening prior to your scheduled appointment to remind you of the appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Payment

Payment for each office visit and related services is due from the patient at the visit. We do not directly bill your insurance carrier or others; however, you will be provided a detailed receipt that you may use for insurance or other reimbursement. We do accept certain credit cards and will utilize these cards if you desire. Such credit card transactions do require interaction with the Credit Card Company or bank. No protected health information is disclosed during such transactions apart from the date of the appointment and charges incurred at that appointment.

Change of Ownership

In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by this practice.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints

Complaints about your privacy rights or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201