Welcome to our office

Date (Fecha)_______________________

Last Name (Apellido)___________________ First Name_________________

Address (Direccion)____ Apt:______

City (Ciudad)_____________________State(Estado)____________Zip Code_________

Phone Number (Telefono):_________________Cellphone(Cellular)_________________

Email (Correo Electronico)_______________________ SS#_____________________

Age:____ Date of Birth (Fecha de Nac)__________ Gender_____

Marital Status (Estado Marital)____________ Ethnicity (Etnicidad)____________

Preferred Language (Idioma preferido)_________________

Occupation (Ocupacion)_____________________

Employer (Empleador)____________________________Work Phone:______________

Referred by (Referido por):____________________________________

Primary Doctor (Doctor primario):______________________Phone:________________

Emergency Contact: (Contacto de Emergencia)__________________________________

Relationship (Relacion): ____________________ Phone (Telefono):________________

HIPAA
Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure the personal information protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and we will do all we can to secure and protect your privacy. When it is appropriate and necessary, we will provide the information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your medical records. We may have direct treatment relations with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). You may revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:___________________________________

Signature:_____________________________________

Witness:______________________________________

Date:____

WEIGHT MANAGEMENT PROGRAM
WAIVER AND RELEASE OF LIABILITY FORM

DESIGN

Each week participants will receive a Lipotropic Injection with accordance to the guidelines in the coupon administered by the medical team. These injections will be recorded at every visit and should be received weekly or bi-weekly.

EXCLUSION CRITERIA

If you are under the care of a physician for a medical condition that may interact with the shots or taking prescription drugs you may participate only with written permission from your physician if it contraindicates the Lipotropic Injections. The only know allergy is to Sulfa drugs.

VOLUNTARY PARTICIPATION

I am voluntarily participating in the Associates MD Weight Loss Program. I reserve the right to refuse to participate in this program or withdraw at any time.

WAIVER AND RELEASE OF LIABILITY:

For and in consideration of the opportunity to participate in the, Associates MD Weight Loss Program and for other valuable consideration, the receipt and sufficiency of which is hereby acknowledged, for and on behalf of myself and my personal representatives, family, heirs, successors, assigns, and next of kin I ___________________________________ (Name of participant) do hereby fully and forever waive, release, discharge and covenant not to sue Associates MD Medical Weight Loss Program, its successors, assigns, parents, subsidiaries, affiliates, owners, employees, representatives, officers, agents, contractors and directors (each considered one of the "Releasees" hereunder) from any and all liability, actions, causes of action, suits, proceedings, controversies, damages, judgments, executions, claims, and demands whatsoever, in law, equity or otherwise, that may arise and that may be caused or alleged to be caused, in whole or in part, by the negligence or intentional conduct of one or more of the Releasees or otherwise, including, but not limited to, any claim of personal injury, medical complications, allergic reactions, death, property damage or failure to achieve my desired health benefits. I intend this Waiver and Release of Liability to be effective whether or not any accident, loss, damage, injury or death results from the negligence or intentional misconduct of one or more of the Releasees.

I agree that if, despite this Waiver and Release of Liability, I, or anyone on my behalf including, but not limited to, my personal representatives, family, heirs, successors, assigns, and/or next of kin, makes a claim or claims against any or all of the Releasees, I will indemnify and hold the Releasees (or any one of them) harmless from any and all litigation expenses, attorney fees, claims, judgments, losses, liability, damages or costs which may be incurred by the Releasees (or any one of them) as a result of and/or in association with such claim or claims.

I have read and I voluntarily sign this Waiver and Release of Liability Agreement. I fully understand its terms, I understand that I have given up substantial rights by signing it and I have signed it freely and without any inducement or assurance of any nature and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law. I agree that if any portion of this agreement is held to be invalid or unenforceable, the remainder shall continue in full force and effect to the maximum extent allowable by law. This Waiver and Release of Liability has no expiration date.

Signature: ____

Print Name: ____

Date: ____

Patient Name:____________________________Date: ________

Please acknowledge that all shots purchased with the Groupon coupon must be used by the deadlines below upon starting the program, not upon the date of purchase of the coupon. If shots are not completed by the dates as stated below, patient will be subject to forfeiture of remaining shots.

Purchased 40 shots: 1 year from start date
Purchased 25 shots: 8 months from start date
Purchased 15 shots: 6 months from start date

Signed Patient:_______________________________________