ASSOCIATES MD

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:_____

DATE:_____

Please note that the diet appointments will not be billed to your insurance.

But if you do have insurance we will bill your insurance for the EKG portion of the visit.
You are not financially responsible for these charges if your insurance company does not pay for the EKG.

If you see the doctor for any visit outside of the diet appointment, including an appointment to clear you for the diet if it was not part of your diet package, then you will be asked to sign a new financial responsibility form and your insurance will be billed for charges.

Diet appointments are all inclusive charges all prices will be quoted up front.

You will be asked to pay for all medications at the time of service; no payment plans will be established.

Please provide your insurance information below so we can bill for the EKG portion of the diet visit. If you do not currently have insurance please let us know.

Print Name:_____

Signature:_____

Insurance Carrier:

Primary Insurance:_____

Policy number:_____

Secondary Insurance:_____

Policy Number:_____

We will ask for a copy of your insurance card at the time of check-in or check-out.

WAIVER AND RELEASE OF LIABILITY FORM

INTRODUCTION

The purpose of the Associates MD, LLC- Weight Management Program is to provide a lifestyle intervention of low glycemic index eating, exercise, nutritional and pharmaceutical intervention, and a menu plan to empower participants to achieve their weight loss goals.

DESIGN

The program will be conducted over a period of monitored sessions. Each appointment participants in the program will follow the guidelines administered by the medical team.

EXCLUSION CRITERIA

If you are under the care of a physician for a medical condition or taking prescription drugs you may participate only with written permission from your physician if it contraindicates the hCG Medication, Phentermine, Ampheta HCL or Lipotropic/B12 Vitamin Injections.

VOLUNTARY PARTICIPATION

I am voluntarily participating in the Associates M.D. Medical 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 M.D. Medical 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 M.D. 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: _____

MEDICAL QUESTIONAIRE

Patient Name:_____
Date of Birth:_____
Date:_____

Please check if you have had any of these symptoms in the last six months:

Females only please fill out the section below:

Could you be pregnant? (Y/N)

Are you breastfeeding? (Y/N)

Do you have irregular periods? (Y/N)

If applicable when was your last period?

Have you ever had breast cancer? (Y/N) If yes when_____

Have you ever suffered from Ovarian Cysts? (Y/N)
If yes when_____

Have you ever suffered from Uterine Fibroids? (Y/N)
If yes when_____

Have you ever had a pulmonary embolism? (Y/N)
If yes when_____

Do you suffer from atherosclerosis or any other cardiac history? (Y/N) If so what:

_____

Do you use or abuse alcohol? (Y/N) How many drinks per week?_____

Do you smoke or have you ever smoked? (Y/N) when:_____ how much per day?_____

Do suffer from any medical allergies? (Y/N) what:_____

Could you be or are you planning to get pregnant? (Y/N)

Do you have a history of mental illness?

Family History:

Do you have any one in your immediate family that has a history of:

Stroke (Y/N) who?_____

Heart Attack(Y/N) who?_____

High Blood Pressure (Y/N) who?_____

Heart surgery or other cardiac problems:(Y/N)__who:_____

Males Only:

Have you ever had a pulmonary embolism? (Y/N)
If yes when_____

All patients:
Do you suffer from any medication allergies? Yes no what?_____

Please be prepared to disclose all medications that you are currently taking at the time of your initial visit.

Nutrition Survey

1. How would you describe your current diet?
   a. Poor
   b. Fair
   c. Good
   d. Very good
   e. Excellent

2. How is your body weight?
   a. I am overweight
   b. I am of normal weight, but am gaining weight
   c. I am of normal weight
   d. I am underweight
   e. I am not sure

3. If you are overweight, how much weight would you like to lose? _____ pounds

4. What would you most like to change about your current diet?

   _____
   _____
   _____
   _____
   _____

5. What are the main reasons that you would like to change your diet?
   a. Improved self-confidence
   b. Improved health
   c. Weight loss
   d. Increased energy
   e. Others (family, friends, others) want me to do so
   f. Improved athletic performance
   g. Strong family history of heart disease or diabetes
   h. To encourage my children or other family members to adopt a healthier diet (to set a good example)
   i. Other:_____
   j. Other:_____

6. What diets or eating plans have you tried in the past, if any?

   _____
   _____

7. How many meals do you eat per day?_____
8. How many snacks do you eat per day?_____

9. How often do you exercise?
   a. Daily
   b. 5-6 times a week
   c. 3-4 times a week
   d. 1-2 times a week
   e. Rarely or never

10. If you currently exercise, how long do your sessions last?
   a. 15-30 minutes
   b. 30-45 minutes
   c. 45-60 minutes
   d. Longer than 1 hour

11. What obstacles do you face when trying to improve your diet?
   a. Emotional or mental stress
   b. A sedentary job/lifestyle
   c. Lots of food at work
   d. Difficulty finding time to prepare or eat nutritious food
   e. An active social life
   f. Frequent travel
   g. Others not supporting, or actively hindering, your attempts to improve diet/health
   h. Many work and family commitments
   i. Health problems
   j. Other:_____

12. What would help you to become more successful in your efforts?
   a. Keeping a food journal
   b. Sample menus
   c. Group classes or meetings
   d. Individual meetings with a registered dietitian
   e. Ideas for budget-friendly and healthy meal/snack ideas
   f. Ideas for better food choices when dining outside of the home
   g. Stress management tools
   h. An exercise plan
   i. Other:_____

13. Are there any major food groups that you dislike or avoid because of preference, allergy, or personal beliefs (ie, meat, milk, fruits, vegetables, starches, etc)?
   a. Yes:_____
   b. No_____