



PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Remedy Weight Loss Clinics to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- The day-to-day healthcare operations of Remedy Weight Loss Clinics practice.

I understand that Remedy Weight Loss Clinics reserve the right to change the terms of this notice from time to time and that I may contact the clinics at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Remedy Weight Loss Clinics are not required to agree to these requested restrictions. However, if Remedy Weight Loss Clinics do agree, Remedy Weight Loss Clinics are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name _____

Signature _____

Remedy Health Profile

First Name: _____ Last Name: _____ Date of Birth: _____

Weight: _____ lbs. Weight 1 year ago: _____ lbs. Min. Adult Weight: _____ lbs at age _____

Max. Weight : _____ lbs. at age _____ Height: _____ Do you Exercise ? Yes No

If you do exercise, what kind of exercise do you do ? _____

How Often? _____

Have you been on a diet before? Yes No _____

If yes, please specify which diet and why you think it didn't work for you (e.g. too rigid, too much cooking involved..etc):

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Remedy's medically supervised weight loss method (10 being the most important): _____

Family Life:

What is your marital status? M S D W Do you have children? Yes No

Number of Children: _____ Ages: _____

Medical Information:

Please list any physicians you see and their specialty:

Diabetes:

Do you have diabetes? Yes No (If no, skip to next section)

If so, are you under the care of a physician? Yes No

If so, which type?

[] Type I – insulin dependent (insulin injections only)

[] Type II – non-insulin dependent (diabetic pills)

[] Type II – insulin dependent (diabetic pills and insulin)

Is your blood sugar level monitored? Yes No

If so, by whom? Myself Physician Other (specify): _____

Are you taking any medication? Yes No If so, please List: _____

Do you tend to be hypoglycemic? Yes No

Cardiovascular Health:

Have you had a cardiovascular event (heart attack, stroke)? Yes No (if no, skip to next section)

If so, please specify: _____ How long ago ? _____

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

Do you have a history of a heart arrhythmia? Yes No

Hypertension:

Do you have high blood pressure? Yes No (if no, skip to next section)

If so, do you have your blood pressure checked on a regular basis? Yes No

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list medicine, dosage, frequency:

Liver Health:

Do you have liver problems? Yes No If so, please specify: _____

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list: _____

Kidney Health:

Have you been diagnosed with kidney disease? Yes No (if no, skip to next section)

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____ Have you ever had Gout? Yes No

Colon Health:

Do you have: Irritable Bowel Colitis Diarrhea Diverticulosis Crohn's disease Constipation ?

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Stomach/Digestive Health:

Do you have: Acid reflux Gastric Ulcer Heartburn Celiac Disease ?

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Ovarian/Breast Health:

Check off the situations that apply to you currently:

- Irregular Periods Menopause Fibrocystic Breast Disease Painful Periods
- History of Hysterectomy (year _____) Pelvic Inflammatory Disease Endometriosis
- Heavy Periods Amenorrhea Uterine fibroma Cancer (uterus, breast)
- Other: please list _____

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Please indicate the date of your last menstrual cycle: _____

Are you currently pregnant or believe that you may be pregnant? Yes No

*Please note that you may not participate in the Remedy Weight Loss program if you are pregnant or believe you may be pregnant.

Thyroid Function:

Do you have thyroid problems? Yes No (if no, skip to next section)

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Emotional Evaluation:

Do any of the following apply to you? (if no, skip to next section)

- Depression Anxiety Panic Attacks
- Bulimia (or history of) Anorexia (or history of)

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Inflammatory Conditions:

Do any of the following apply to you? (if no, skip to next section)

- Migraines Fibromyalgia Rheumatoid Arthritis Lupus Osteoarthritis Chronic Fatigue Syndrome
- Psoriasis Other autoimmune or inflammatory condition: _____

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No

If so, please list: _____

Allergies:

Do you have any **food** allergies? Yes No

If so, please list: _____

Do you have any **medication** allergies? Yes No

If so, please list:

General:

Do you have Cancer? Yes No

Are you in cancer remission? Yes No

If so, please specify and indicate for how long: _____

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list: _____

Are you generally fatigued or have low energy? Yes No

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Do you get cold easily? Yes No

Do you have cold hands/feet? Yes No

Do you have other health problems? Yes No

If so, please specify: _____

If so, are you under the care of a physician? Yes No

Are you taking any other medications not listed above? Yes No

If so, please list: _____

Are you currently taking Vitamins, Herbs or Supplements? Yes No

Vitamin, Herb or Supplement Name & dosage

Reason

1. _____

2. _____

3. _____

4. _____

Eating Habits: (please be as honest as possible so that we may better help you)

Breakfast – Do you have **breakfast** every morning? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Do you have a **snack before** lunch? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Lunch – Do you have **lunch** every day? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Do you have a **snack before** dinner? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Dinner – Do you have **dinner** every day? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Do you eat a **snack at** dinner? Yes Sometimes Never

Approximate Time: _____ Examples: _____

Other:

Do you prefer: [] Sweet foods [] Salty foods [] Fatty foods

Are you a vegetarian? Yes No

How many glasses of water do you drink per day? _____ glasses

How many cups of coffee do you drink per day? _____ cups Do you smoke? Yes No
If you do smoke, how many packs per day? _____ for how many yrs ? _____
Do you drink alcohol? Yes No
If yes, what, how much and how often? _____

CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger Score each item on a 0-10 numbering scale. Each feeling represents a different part of the brain and different neurotransmitters

Compulsions/Cravings

Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

Never Occurs 0 1 2 3 4 5 6 7 8 9 10 Constant

Appetite

Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

Never eat more 0 1 2 3 4 5 6 7 8 9 10 Always eat more

Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

0 1 2 3 4 5 6 7 8 9 10
Leave food on plate one plate only second's thirds

Hunger

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

Never hungry 0 1 2 3 4 5 6 7 8 9 10 Constant hunger

You must take vitamins and minerals while you are on the Remedy Weight Loss Method. If you stop taking them, you may experience undesirable side effects. _____ (Clients initials)

If you are taking medications, are you interested in getting off any of all of your prescription medications?

[] Yes [] No

If you have health problems not indicated on this health profile, please consult your physician.

Signature: _____ Date: _____

The signatory client hereby recognizes the accuracy & validity of the information provided herein and that he/she has made an informed decision to go on the Remedy Weight Loss Method.

Remedy Weight Loss Systems

Consent Form for Treatment with Prescription Weight Loss Medication

I acknowledge that I have received information regarding treatment with anorectic medications, including precautions, side effects, and risks involved with taking these medications. I have had a chance to ask questions about the medications and my weight loss program.

I have received, read, and acknowledged the Privacy Policy and Practices.

I understand that the appropriate candidate must meet the following criteria:

1. Must be minimum of eighteen (18) years of age.
2. Cannot be pregnant or breast-feeding.
3. Must be at least 20% above ideal body weight range.

I understand that the following are known risk factors for taking anorectic medications:

1. Increased risk of complications if an anesthetic is administered while I am taking these medications.
2. Increased blood pressure.
3. Increased heart rate.
4. These medications may interact with or affect other medications.
5. These medications may cause a drug screen to be positive for amphetamines.
6. There is a lack of scientific data regarding the potential danger of long term use of combination weight loss treatment and there are potential benefits versus risks with weight loss treatment.

I understand that for my weight loss program to be effective, I must also exercise, eat a sensible balanced diet, and learn to change my lifestyle habits.

Please list any active medication(s) you are currently taking including OTC/herbals:

Medication(s)	Dosage	Reason

First Name: _____

Last Name: _____

Today's Date: _____

Date of Birth: _____

Sex: Male Female

Home Phone: _____

Cell Phone: _____

Street Address: _____

City & State: _____ Zip: _____

Email: _____

How did you hear about us? Radio Billboard Advertisement in _____

Facebook Groupon Referred by _____ Website Other _____

DO NOT WRITE

IN THIS SPACE

Health History: Have you ever had any of the following? Please explain.

- | | | |
|-----|-----|--|
| Yes | No | |
| ___ | ___ | Asthma or other lung disease |
| ___ | ___ | Kidney disease |
| ___ | ___ | Diabetes |
| ___ | ___ | Peptic ulcer or other stomach/intestinal disorder |
| ___ | ___ | Psychiatric or nervous disorder (depression, anxiety, bipolar) |
| ___ | ___ | Heart or blood Pressure (Hypertension) |
| ___ | ___ | Thyroid disease |
| ___ | ___ | Seizures, convulsions, or fainting |
| ___ | ___ | Neurologic disorder, stroke, TIAs |
| ___ | ___ | Migraines |
| ___ | ___ | Glaucoma |
| ___ | ___ | Any other disease, illness or condition |
| ___ | ___ | Allergic to Shellfish |

ANY SURGERIES? (please list): _____

ALLERGIC TO ANY MEDICINES? (please list): _____

Date _____ Signature _____

Title XXXIII REGULATION OF TRADE, COMMERCE, INVESTMENTS, AND SOLICITATIONS - Chapter 501 CONSUMER PROTECTION 501.0575 Weight-Loss Consumer Bill of Rights.--
 (1) The Weight-Loss Consumer Bill of Rights shall consist of the following provisions: (A) WARNING: RAPID WEIGHT LOSS MAY CAUSE SERIOUS HEALTH PROBLEMS: RAPID WEIGHT LOSS IS WEIGHT LOSS OF MORE THAN 1 1/2 POUNDS TO 2 POUNDS PER WEEK OR WEIGHT LOSS OF MORE THAN 1 PERCENT OF BODY WEIGHT PER WEEK AFTER THE SECOND WEEK OF PARTICIPATION IN A WEIGHT-LOSS PROGRAM. (B) CONSULT YOUR PERSONAL PHYSICIAN BEFORE STARTING ANY WEIGHT-LOSS PROGRAM. (C) ONLY PERMANENT LIFESTYLE CHANGES, SUCH AS MAKING HEALTHFUL FOOD CHOICES AND INCREASING PHYSICAL ACTIVITY, PROMOTE LONG-TERM WEIGHT LOSS.
 (D) QUALIFICATIONS OF THIS PROVIDER ARE AVAILABLE UPON REQUEST. (E) YOU HAVE A RIGHT TO:
 1. ASK QUESTIONS ABOUT THE POTENTIAL HEALTH RISKS OF THIS PROGRAM AND ITS NUTRITIONAL CONTENT, PSYCHOLOGICAL SUPPORT, AND EDUCATIONAL COMPONENTS.
 2. RECEIVE AN ITEMIZED STATEMENT OF THE ACTUAL OR ESTIMATED PRICE OF THE WEIGHT-LOSS PROGRAM, INCLUDING EXTRA PRODUCTS, SERVICES, SUPPLEMENTS, EXAMINATIONS, AND LABORATORY TESTS.
 3. KNOW THE ACTUAL OR ESTIMATED DURATION OF THE PROGRAM.
 4. KNOW THE NAME, ADDRESS, AND QUALIFICATIONS OF THE DIETITIAN OR NUTRITIONIST WHO HAS REVIEWED AND APPROVED THE WEIGHT-LOSS PROGRAM ACCORDING TO s. 468.505(1)(j), FLORIDA STATUTES.
 (2) The copies of the Weight-Loss Consumer Bill of Rights to be posted according to s. 501.0573(6) shall be printed in at least 24-point boldfaced type on one side of a sign. The palm-sized copies to be distributed according to s. 501.0573(5) shall be in boldfaced type and legible. Each weight-loss provider shall be responsible for producing and printing appropriate copies of the Weight-Loss Consumer Bill of Rights.
 History.--s. 4, ch. 93-274; s. 45, ch. 2000-154.