Arlington Office

Physician's Weight Control and Wellness

716 Lincoln Square

Arlington, TX 76011

817-277-3469

fax 817-277-9309

www.DrWeightControl.com

Thank you for choosing Physician's Weight Control and Wellness to help you on your **weight loss journey.**

Please complete the attached forms and return them to our Arlington office.
Your completed forms may be scanned and emailed to our office – Arlington@DrWeightControl.com. Or you can fax them to 817-277-9309, mail them to the address above or bring them prior to your first appointment. (Please be sure all forms are filled out.)

See you soon!

Arlington Office Staff

NOTICE: *Please be aware of associated risks of email transmission. If you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We will try to insure, but cannot guarantee, that information transmitted through email will remain confidential. You have access to a patient portal with our office upon registering as a new patient. Please consider communicating here.*

Arlington Office

Physician's Weight Control and Wellness

716 Lincoln Square

Arlington, TX 76011

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fax 817-277-9309

www.DrWeightControl.com

Arlington Office New Patient No-Show Policy

*It is the policy of **Physician's Weight Control & Wellness** to charge a $50.00 non-refundable no-show fee before your first appointment. (This fee will be deducted from the cost of your first appointment.) Should you fail to appear for your scheduled appointment at the designated time and/or fail to reschedule two (2) or more business days prior to your appointment, you will forfeit your $50 pre-payment in full. You will then be required to pay another $50 fee in order to schedule another appointment. By providing us with your credit card information or sending money order/cashier's check or bringing in cash for your pre-paid fee you are acknowledging the receipt and understanding of this no-show policy.*

Dear Patient,
It is our pleasure to welcome you to our office. Hopefully the information enclosed in this letter will help make your appointment more efficient. Attached is a brief medical history, consent forms, and other needed documents. Please fill out these forms and bring them with you to your first visit. You may also download these forms on our website at www.DrWeightControl.com. **If you scan and e-mail the forms back to us please send them to Arlington@DrWeightControl.com**

New Patient Charges:

Inital Office Visit : $135.00
Lab Work : $ 80.00
EKG : $ 50.00

TOTAL FEE :
$265.00 for your first appointment
less the $50.00 pre-paid fee
= $215.00 due at time of your first appointment
(credit or debit card, cash, or money order only)
(no checks accepted)
Fees due on day of visit prior to your appointment

Useful Information:

Please notify our office BY PHONE prior to your first visit if you have a heart condition requiring medication.

• In order to better serve you, as well as all of our patients, please do not be more than 15 minutes late. Being more than 15 minutes late could result in rescheduling your appointment and forfeiting your $50 no-show fee. **If you need to change your appointment, please allow 2 business days (Mon-Thurs) before your scheduled appointment. Appointments not rescheduled within this time frame, or missed, will forfeit the full $50 consult fee.**

• We do not accept any insurance. Payment is due on the day of service. We accept cash, credit or debit cards. **Our office does not accept personal checks.** The charge for your first visit will be $265.00 less the $50.00 deposit for a balance of $215.00.

• We do lab work on all new patients. To ensure the most accurate results please fast 6 to 8 hours before your appointment. ***You should have nothing to eat during that time.*** You are encouraged, however, to drink plenty of water or black coffee (no sugar or cream) during your fasting hours. If your appointment is late in the day we do not expect you to go all day without eating, so just eat light. That means nothing sugary or fatty. We will be checking your glucose level, cholesterol, triglycerides, thyroid, and getting a general wellness profile. The results will be discussed with you on your second visit. If there is a result that is dangerously out of range, one of our providers will call and advise before your next scheduled appointment.

• We require that you have an EKG which will also be done on your first visit. We ask that you do not wear lotion, body oil, Vaseline, or any other products that could make your skin feel oily. We need your skin clean and free of products the day of your visit. Ladies, please wear a 2-piece outfit, not a dress.

• We will be doing a body composition analysis on your initial visit. This will give us your weight and BMI (body mass index). Please wear shoes that are easy to take off. Ladies, please do not wear pantyhose on your first visit. We will need you to step on the BMI scale with your bare feet in order to get an accurate reading.

• On your first visit, the doctor will prescribe a plan of treatment which may include any or all of the following: a variety of supplements, an optional Vitamin B with Lipo injection, an exercise program, meal plans, and medications when appropriate.

On your initial visit to our office we request that you make arrangements for child care. This is an important time for you and the Doctor to discuss your history and develop your own personalized plan for weight loss. We have found the most success on this visit comes with as few distractions as possible.

We look forward to meeting you.
If you have any questions please call, or check our website www.DrWeightControl.com

See you soon!
PWCW Staff

F.A.Q.

Insurance
Insurance companies have historically NOT covered weight loss; however, some are becoming more receptive to the idea of treating obesity. We do not file insurance in the office at this time but we will supply you with a Super Bill which provides you all the information you need to file your own claim for reimbursement.

Payment
We accept cash, MasterCard, Visa, Discover, American Express and all debit cards. **Personal checks are not accepted.**

Hours
Because our doctors rotate between two offices, our hours vary greatly from office to office. Please call for an appointment at the office of your choice.

Appointments
Appointments are necessary. Our new patient appointments could be scheduled several weeks out. Please plan ahead and call to schedule. There is a $50 non-refundable consult fee required for initial visit appointments.

Established Patient Charges
Your monthly (every 4 weeks), recurring price for follow-up visits will be $110.00. This charge includes consultation with the Doctor, a Vitamin B with Lipo injection, supplements and a prescription for an appetite suppressant which will need to be filled at a pharmacy of your choice. (additional cost at the pharmacy)

****Any time a patient consults with a provider in-office or via telemedicine, for any reason, the fee is $110.00.**

New Patient No Show Policy

It is the policy of Physician's Weight Control & Wellness that should you fail to appear for your scheduled appointment at the designated time and/or fail to reschedule two (2) or more business days prior to your appointment, you will forfeit your $50 deposit in full. You will then be required to pay another $50 deposit in order to schedule another appointment. By providing us with your credit card information, or sending a money order or a cashier's check, or bringing in cash for this deposit you are acknowledging the receipt and understanding of this New Patient No Show Policy.

No-Show Defined:

Failing to reschedule your appointment at least 48 hours before appointment time in one of the following ways will be considered a NO SHOW.

1. Talking directly to someone on our staff
2. Rescheduling by responding to your appointment email/text
3. Calling and leaving a clear message (first and last name, date of birth, date and time of appointment) on our answering machine. (After hour cancellation messages may be left by calling 817-277-3469. All messages are recorded and kept.)

In addition, arriving late to your scheduled appointment time will be considered a no-show and will result in rescheduling. If you are stuck in traffic, trying to get to our office, and find you will be a couple of minutes past your appointment time **PLEASE CALL OUR OFFICE IMMEDIATELY**.
We will try to work with you to avoid a no-show for the day resulting in a loss of your deposit.

Established Patient No-Show Policy

716 Lincoln Square
Arlington, TX 76011
817-277-3469 fax 817-277-9309

The Physician's Weight Control & Wellness is dedicated to providing the highest quality care to our patients and we want to thank you for the privilege of being able to help you succeed in becoming a healthier you.

Recently we have been experiencing an increased number of patients who have either not shown up or called to cancel their appointment 24 hours before their appointment time. In an effort to correct this problem we have found it necessary to follow the lead of other doctor's offices and implement a No-Show Policy.

Read carefully. If you have questions about the guidelines of this Policy please ask before signing.

No-Show Defined: Failing to cancel your appointment by talking to someone on our staff, or calling and leaving a clear message (first and last name, date of birth, date and time of appointment) on our answering machine **at least 24 hours before your appointment time** to cancel your appointment will be considered a no-show. After hour cancellation messages may be left by calling 817-277-3469. All messages are recorded and kept. *Please do not send an email to info@drweightcontrol.com to cancel or change your appointment. This is not a monitored email address and corresponding through this address will result in a no-show charge.*

Showing up 15 minutes or more after your scheduled appointment time will be considered a no-show and will result in rescheduling. If you are stuck in traffic and trying to get to our office and find you will be a couple of minutes past the 15-minute deadline ***PLEASE CALL OUR OFFICE IMMEDIATELY.*** We will try to work with you to avoid a no-show for the day.

Our Policy: If you miss your appointment without rescheduling at least 24 hours before the time of your appointment or if you are more than 15 minutes late you will be charged a $25.00 no-show fee for that missed appointment. The fee will be due when you come in for your next appointment. (If you have two consecutive no-show appointments you will not be able to schedule another appointment without first paying $50.00 for the two missed appointments.)

We truly regret having to implement a policy such as this, but in fairness to our patients who need to make an appointment and could have been scheduled at the time of a no-show patient, we need to take actions necessary to see that our appointments are open and available for our patients. Thank you for understanding.

Physician's Weight Control and Wellness, Arlington Office

I have read and understand this No-Show Policy

Patients Name: ____ Date of Birth: ____________________

Date: ______________________

Yes, I would like to have a copy of this No-Show Policy ___________

No, I do not need a copy of this No-Show Policy (if no, please initial on the line) ___________

PWCW reserves the right to make changes to our No-Show Policy at any time.

Should changes occur you will be notified and the new policy will be posted on our website.

Office Use Only:

This no-show policy was reviewed with patient by __________(staff initial)

Patient Privacy Questionnaire (HIPAA)

Name of Patient: ____ **Date of Birth:** _________________

Names and contact numbers of persons, if any, we may contact in an emergency.
(name)____________________________________ (phone #)__________________________________
(name)____________________________________ (phone #)__________________________________

Name of person who has permission to cancel or reschedule appointments for you.
(name)_______________________________ (relationship)______________(date of birth)___________

If you would like correspondence from our office sent to an address other than your home please specify:
____

Are there any special instructions how correspondence may be sent to you?
____

Please provide an e-mail address we could send correspondence to:
____

**** May we email an appointment reminder to you?** ______Yes ______ No

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Cell phones, voicemail, and answering machines are not completely private.

Home Phone: ____
May we leave a message on the answering machine? ______ Yes ______No
If someone answers your home phone may we leave a message with that person? Yes _____No

Cell Phone: ____
May we leave a message on the answering machine? ______ Yes ______No
If someone answers your home phone may we leave a message with that person? Yes _____No

Work Phone: ____
May we leave a message on the answering machine? ______ Yes ______No
If someone answers your home phone may we leave a message with that person? Yes _____No

PATIENT'S NAME (please print): ____

SIGNATURE: ____ DATE: __________

NOTE: This signed Privacy Questionnaire will remain in your file and considered current. If there are any changes you must notify our office and complete another form.

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.*

PHYSICIANS weight control & wellness

PATIENT MEDICAL HISTORY- ARLINGTON OFFICE

Today's Date:

Patient's Last Name:	First:		Middle:	Preferred Name:
Date of Birth:	Age:	Sex:	Marital Status:	Social Security # (opt)

Street Address:	City and State:	Zip Code:

Home Phone:	Cell Phone:	E-mail Address:

Occupation:	Job Title:	How Long:	Work Phone:

Employer:	Employer's Address:

Spouse's Name:	Spouse's Employer:	Spouse's Phone:

Relative other than at your home address:	Relationship:	Phone Number:

Children's Names and Ages:	How did you hear about us?

PATIENT HISTORY (please check all that apply):

General	Head / Ears / Nose / Throat	Pulmonary	
__ Unplanned Weight Change __ Fevers __ Chills __ Sweats __ Loss of Energy __ Fatigue	__ Visual Problems __ Glasses / Contacts __ Cataracts __ Hearing Problems __ Sore Throat __ Sinus Infection	__ Cough __ Wheezing __ Shortness of Breath __ Positive TB Test __ Snoring __ Headache upon Waking	__ Fall Asleep at Wheel __ Asthma __ Never Feel Rested __ Sleep Study Done Results: ________________ __ Insomnia

Cardiac	Gastrointestinal		Genitourinary	Metabolic
__ Chest Pain with Exertion __ Chest Pressure __ Irregular Heart Beat __ Palpitations __ Congestive Heart Failure __ Rheumatic Fever	__ Abdominal Pain __ Trouble Swallowing __ Nausea __ Vomiting __ Dark / Black Stool __ Yellow Jaundiced	__ Diarrhea __ Constipation __ Bright Red Blood in Stool __ Hemorrhoids __ Stomach Ulcers __ Heartburn or Reflux	__ Blood in Urine __ Hesitancy __ Kidney Stones __ Frequent Urination __ Prostate Problems __ Discomfort-Urination	__ High Blood Pressure __ Diabetes __ High Cholesterol __ Thyroid Problems __ Other: ____________

Hematological	Neurological	Musculoskeletal	Psychological	Gynecologic / Other
__ Abnormal Bleeding __ Easy Bruising __ Blood Clots in Legs/Lungs __ HIV, AIDS __ Nose Bleeds __ Hepatitis B __ Hepatitis C	__ Severe Headaches __ Chronic Headaches __ Migraines __ Dizziness __ Passing Out __ Seizure / Epilepsy __ Stroke	__ Joint Pain __ Swelling in Extremities __ Back Pain __ Pain in Legs __ Leg Ulcers __ Varicose Veins __ Leg Cramps	__ Depression __ Anxiety __ Shaking __ Emotional Upsets __ Ever received psychiatric/psychological treatment	__ Breast Pain __ Breast Lumps __ Breast Discharge __ Menopause __ Irregular Cycle Last Cycle: ____________

PLEASE LIST ALL THE DIET PROGRAMS YOU HAVE USED IN THE PAST AND YOUR RESULTS:

__ Phentermine ____
__ Phen-Fen, Redux ____
__ Meridia ____
__ Other : ____

List **ALL** prescriptions and over-the-counter medications presently using:______________________________
List **ALL** prior surgeries and dates:______________________________
List **ALL DRUG** allergies: ______________________________

Do you exercise?	What kind?	How much?

Do you:	Eat breakfast?	eat lunch?	eat dinner?	eat between meals?	eat at night?	eat when stressed?

Do you take:	vitamins?	laxatives?	hormones?	Pain medication?	Stomach medication?	birth control pills?	nerve medication?

cold medication?	herbal supplements? (name)

Do you smoke?	How much?	Do you use caffeine?	How much?	Do you drink alcohol?	How much?

In the past year, have there been any changes in your family?*(Check all that apply)* __ Marriage __ Separation __ Divorce __ Loss of Job __Birth __ Serious Illness __ Death __ Other

PATIENT'S SIGNATURE :	**PHYSICIAN'S SIGNATURE:**

Current Medication List

***Please fill this form out completely*.**

The doctor will need to review all your medications each time you are in our office.

You may be asked to complete this form more than one time during the year.
It is very important that our providers have an updated list of all your medications at all times.

Today's Date ____

Patient's Name ______________________________ **Date of Birth**____________

If there is ever a change in your medications let us know as soon as possible.

List ALL medications you are currently taking (prescriptions, over the counter, vitamins, minerals, etc.)

Name of Medication	Strength	How many times a day do you take this medication?	How long have you been taking this medication?	Name of doctor

Do you have an allergy to any drugs?

Please list ALL prescriptions, over the counter, etc. drugs you are allergic to.

Physician's Weight Control and Wellness

Notice of Privacy Practices Confidentiality of Your Health Care Information

January 31, 2019

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

We are required by law to provide you with this notice of our legal duties and privacy practices concerning your private health information. By law we must follow the terms of the Notice of Privacy Practices that we have in effect.

If you have questions about this notice, please contact the Privacy Officer at (817) 277-3469

This notice describes Physician's Weight Control and Wellness privacy practices and that of:

- All employees.
- Any intern, volunteer or IT personnel that we allow to input or maintain patient data files.
- All internal departments of Physician's Weight Control and Wellness Center
- All locations owned by Physician's Weight Control and Wellness.

Our Commitment to Your Privacy

We have always had stringent safeguards to protect private health information (PHI), however, because of a new law some changes are necessary to assure you we are dedicated to maintaining the privacy of your health information. In conducting our business, we may receive, create, use, or disclose protected health information regarding you and the treatments and services we provide you. *None of your protected health information will leave our office without your written consent.*

Health Information Security - Physician's Weight Control and Wellness requires all employees to follow security policies and procedures to safeguard your PHI.

Understanding your Medical Record Information - The information we have on you is called your private health information (PHI). We create a record of the care and services you receive in our office. This record will contain your prescription information, doctor's progress notes, medical history or other documentation the doctor chooses to include in your medical record.

To summarize, this notice provides you with the following important information:

- How we use and disclose your PHI.
- Your privacy rights of your PHI.
- Our obligations concerning the use and disclosure of your PHI.

How We May Use and Disclose Medical Information About You

For Treatment - We will use health information about you to provide medical treatment or services. Our doctors, medical assistants and office personnel will all have access to your health information.

For Health Care Operations - We may use your protected health information in order to perform our daily business activities, which may include data management, customer service, complying with laws and quality. Your health information may be used to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer or how we can become more efficient. ***To Avert a Serious Threat to Health or Safety -*** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Research - We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military - If you are, or were, a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks - We may disclose health information about you for public health activities. These activities generally include, but are not limited to the following:

- To prevent or control disease, injury or disability.
- To regulate products subject to FDA regulations.
- To notify the appropriate government agency if we think a patient has been the victim of abuse, neglect, or domestic violence

Health Oversight Activities - We may disclose health information to a health oversight agency for audits, investigations, inspections, accrediting or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws. Generally, these audits are done in our office and will not require a signed consent from you.

As Required by Law - We will disclose health information about you when required to do so by federal, state, or local law enforcement.

Judicial Proceedings -If you are involved in a lawsuit or a dispute and we are ask to disclose health information about you in response to a court order or subpoena we will legally have to comply to those orders. ***Law Enforcement -*** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements. ***Coroners, Medical Examiners and Funeral Directors -*** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death or as necessary to carry out their duties. If you have listed someone you do not want your records revealed to, that person would not be allowed to get a copy of your PHI even in the event of your death.

Information Not Personally Identifiable - We may use or disclose health information about you in a way that

does not personally identify you or reveal who you are. This is usually generic information to help improve or create new medications.

Individuals Involved in the Treatment or Payment of Your Care - We may disclose health information about you to your family members or friends *if* we obtain written consent by you to do so. **Business Associates** – There are some services that we provide through contracts with third party business associates. Examples include external laboratories and information technology associates. To protect your health information, PWCWC requires business associates to sign a disclosure
agreement before they can have access to any information pertaining to the company or patients.

Consent Forms
You may revoke any consent form at any time by giving us written notice. Your revocation will be effective when we receive your written notice. Any disclosures prior to receiving your written revocation of that particular consent form will not be subject to your revocation.

Your Rights Regarding Health Information About You - You have the following rights regarding health information we maintain about you. **Right to Inspect and Copy -** You have the right to inspect and request a copy of certain health information we have on file. Usually, this includes medical and billing records. To inspect and request a copy of health information on file about you, you must submit a written request. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or other associated supplies. (Our office does not use electronic record keeping so your records cannot be transferred to you electronically.) We may deny your request to inspect or receive a copy in certain limited cases. If we deny your request, you may ask for a review of the denial. The person who conducts the review will not be the person who denied the request. We will comply with the outcome of the review. **Right to Request an Amendment -** If you believe medical information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information originated at PWCWC. You must request an amendment in writing and submit it to the Privacy Officer. You must also tell us the reason for your request. The request to amend your record may be denied, in which case you have the right to enter a statement into your record saying that you disagree with the decision. **Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions - You have the right to request a restriction or limitation on the health information we disclose about you for treatment, payment or health care. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. We are not required to agree to your request, but, if we do agree, we will comply with your request unless the information is needed to provide emergency treatment for you. You must submit your request for restrictions in writing to the Privacy Officer. In your request, you must tell us: - The information you want restricted. - To whom you want the restrictions to apply, such as your spouse or another relative. The Privacy Officer will inform you if disclosure is made to someone on your restricted list; this discloser will only be made in case of a health emergency.

Right to Request Confidential Communications - You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You must submit your request for confidential communication in writing. Your request must specify how or where we should contact you. We will try to accommodate all reasonable requests. (We have a form you can use for this purpose.)

Other Uses of Medical Information - Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will only be made with your written permission. If you provide us with permission to use or share your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or share your health information for the reasons in your written revocation. Any information disclosed before your written revocation will not be subject to this revocation.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have, as well as information we receive in the future. We will post copies of the current notice on our website, www.drweightcontrol.com. The notice will contain the effective date of the notice in the top right-hand corner of the first page.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. This notice is also available on our website, www.drweightcontrol.com.

For More Information or to Report a Problem

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation for filing a complaint.

To file a complaint with our office you may contact our privacy officer: Privacy Officer
Physician's Weight Control and Wellness
716 Lincoln Square
Arlington, TX 76011

If there is ever a breach of your personal health information by our office you will be notified immediately.

Our Notice of Privacy Practices has been revised to reflect new rules set forth by the Department of Health and Human Services Omnibus Rule and the HITECH Act.

Physician's **Weight Control and Wellness**

HIPAA Consent Form

I understand that as part of my health care, **Physician's Weight Control and Wellness** originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment,

• a means of communication among other health professionals who contribute to my care, • a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

After reviewing the ***HIPPA Notice of Privacy Practices*** I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax. Any disclosures would be on an emergency or court ordered basis. Any other disclosures will require written consent from you.

I further understand that the **Physician's Weight Control and Wellness** has the right to change their ***Notice of Privacy Practices*** notice in accordance with the Code of Federal Regulations. Should the **Physician's Weight Control and Wellness** change the notice it will be posted on the website www.DrWeightControl.com.

I have been provided and have the right to review the ***Notice of Privacy Practices*** that provides a complete description of how my personal information could be used or disclosed before signing this consent.

With whom may we discuss your treatment and medications provided by this office?

Name: ____ Relationship: ______________________ Name: ____ Relationship: ______________________

I fully understand and ______accept ______decline the terms of this consent.

I understand that after reviewing the ***Notice of Privacy Practices*** if I should choose to decline the terms of the notice I could be denied treatment at **Physician's Weight Control and Wellness Center**.

____ ______________________

Patient's Signature (authorized representative signing for the patient) Date of Birth

____

Date

NOTE: This signed HIPAA Consent Form will remain in your file and considered current.

Yes, I would like to have a copy of this signed HIPAA Consent Form ___________
No, I do not need a copy of this signed HIPAA Consent Form (if no, please initial on the line) ______

FOR OFFICE USE ONLY

[ ] Consent received by _________________________________ on ___________________

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on ________________________________

Arlington Office
Christopher L. Puempel, MD
716 Lincoln Sq
Arlington, TX 76011
817-277-3469 Fax 817-277-9309

Subject: Concurrent Treatment Disclosure –

At Physician's Weight Control and Wellness our patients' health and safety is vitally important to us. With this in mind, it is necessary that each patient fully inform the office staff and/or physician when there is any change in treatment, medication, or care being provided by another medical facility. This disclosure includes any new health issues, or changes in ongoing treatment for any medical condition you may have. In addition, it is absolutely vital that no one under the care of Physician's Weight Control and Wellness be under the care of another facility or clinic for weight management without full disclosure of such to the staff of this office. The decision will be up to the physicians of our clinic to determine if our treatment is medically compatible with any other form of treatment you may be receiving. Furthermore, failure of full disclosure of concurrent weight management treatments could be grounds for dismissal from our clinic. Please know that it is for your health and well-being that we must have a complete and full disclosure of medical or weight loss treatments you are undergoing outside of this facility.

Sincerely,

Christopher L. Puempel, M.D.

I have read the above statement and agree to follow the standards as outlined.

Patient's Signature ____ Date of Birth_________________

Date Signed _________________________________

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. If you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks.*
We cannot guarantee that information transmitted will remain confidential

Physician's Weight Control and Wellness

Patient Informed Consent for Appetite Suppressants and Participation in a Weight Management Program

1. I, ____(patient or patient's guardian) authorize the Physician's Weight Control and Wellness physicians and assistants to assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual patient. I understand that treatment options may involve the use of appetite suppressant medications and other supplements. My treatment may necessitate 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 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. In this office, an appetite suppressant may be used in combination with another appetite suppressant drug and other supplements."

"As a bariatric physician, I believe the possibility of side effects as explained to me 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 for the possible help the appetite suppressants used in this manner may give."

3. I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication(s) and notify the medical staff of the Physician's Weight Control and Wellness as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (take your medications with you)

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. This signed consent will remain current unless I notify the Physician's Weight Control and Wellness otherwise.

DATE:________________________________ **TIME:**__________________________________

PATIENT:_____________________________ **WITNESS:**______________________________

Physician 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. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

____
Physician's Signature

Injection Release

Lipo-B Plus Injections

PRINT YOUR NAME: ____ Date of Birth__________________________

Benefits of Lipo-B Plus Injections

Concentration/Strength

Methionine 25mg

Inositol 50mg

Choline 50mg

Hyeroxocobalamim (B-12) 1000mcg

Pyridoxine (B-6) 175mcg

Lipotropic agents are classes of substances that play an important role in the body's control of fat. Through their involvement in lipid/fat metabolism, they can help maintain a healthier liver. The liver plays an important role in human metabolism and has a number of important functions, including glycogen storage, plasma protein synthesis and detoxification. The liver also produces bile, a compound which aids in digestion and the breakdown of fats. Lipo-B Plus injections include a combination of important amino acids and vitamins and using these injections, along with proper diet and exercise, can help you reach your goal weight faster by giving you an extra boost. Here are some of the benefits:

- Increases and speeds up your metabolism
- Reduces and burns stored body fat
- Increases energy and drive
- Maintains a healthier liver

I have read this information sheet about the Lipo-B Plus injections I wish to receive. I will ask questions, if I have any, before getting the injection.

I agree to remain at the clinic for at least 10 minutes after my injection.

I hereby consent to the administration of Lipo-B Plus injection. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees**, Physician's Weight Control and Wellness** owners and representatives from any and all claims, demands, actions and causes of action, which may result from voluntarily taking these injections.

SIGNATURE: ____ DATE: ____________________

I would like a copy of this consent ______yes ______no

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.*

Arlington Office
716 Lincoln Square Arlington, TX 76011
817-277-3469
www.DrWeightControl.com

Information Regarding Email Communication

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@DrWeightControl.com. The turnaround time for routine patient communications using this email address is three to four business days. **Do not use this email to cancel or reschedule your appointment. Since this is not a routinely monitored email address a no show will result if you miss your appointment.** Do not use this email address to discuss your medications or ask medical questions.

When you are sending email to our office, please put the subject of your message in the subject line so we can process it more efficiently. Be sure to put your name, date of birth and return telephone number in the body of the message. Since this email address goes to one central location, tell us the office you are trying to contact (Arlington or Waco) in your email to us.

Medication Refill Authorizations are to be sent to Arlington@DrWeightControl.com.

Consent for Use of Email Communication

This office is dedicated to keeping your medical record information confidential. Communications relating to diagnosis and treatment will be filed in your medical record. We will not be emailing that information to you.

IT IS YOUR RESPONSIBILITY TO REMEMBER YOUR APPOINTMENT TIME

As a courtesy we try to email appointment reminders but on occasion we are not able to process the reminders.
DO NOT ***depend on receiving appointment reminders to remember your next appointment*****.**
If you miss your appointment it will be considered a no-show regardless of whether or not you get a reminder.
Please initial that you have read and understand that it is your responsibility to remember your appointment time. __________

Please do not use email in emergency situations. Should you require urgent or immediate attention, please call the office or go to the emergency room.

By signing below, you are agreeing that you understand this policy and that we may send correspondence to you via email, and that we may respond to your emails to us via email.

Yes, I would like to have a copy of this Email Policy (please initial on the line) __________

No, I do not need a copy of this Email Policy (please initial on the line) __________

______________________________	______________________________
Patient signature:	Date of Birth:
Your email address:	Today's Date:

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.*

Office Use Only:

This Email Policy was reviewed with patient by __________ (staff initial)

Arlington Office
716 Lincoln Square
Arlington, TX 76011
817-277-3469
www.DrWeightControl.com

Consent for Treatment by a Physician Assistant / Nurse Practitioner

Physician's Weight Control and Wellness employs Nurse Practitioners (NPs) and Physicians Assistants (PAs). At our Arlington office you may be seen by our doctor, or our NP or PA.

Nurse Practitioners and Physicians Assistants are not Physicians or Nurses, but skilled Health Care Practitioners who by formal experience in medical school are qualified to perform certain tasks under the supervision of a physician.

NPs and PAs are board certified and are required to participate in a designated number of hours of continuing medical education each year to maintain that certificate.

You may choose not to be seen by the NP or PA, please indicate below your preference.
This consent will remain in your permanent medical records. You may revoke this consent at any time.

I agree to see the Nurse Practitioner or Physician's Assistant ____________

No, I do not want to be seen by the Nurse Practitioner or Physician's Assistant ____________

Patient'sName:____ Date of Birth: ____________________

Today's Date: ____

Otto F. Puempel, D.O.
Christopher Puempel, M.D.
716 Lincoln Square Arlington TX 76011
817-429-2929 Fax 817-277-9309
www.DrWeightControl.com

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED MEDICATION PRESCRIPTIONS

Controlled substance medications ***(i.e. narcotics, tranquilizers and barbiturates)*** are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to manage specific medical conditions, thus improving quality of life. Because my physician is prescribing controlled substance medications to help manage my medical condition, I agree to the following conditions:

1. **I am responsible for the controlled substance medications prescribed to me.** If my prescription is lost, misplaced or stolen or if I "run out early," **I understand that it will not be replaced**.

2. **Refills** of controlled substance medications:
   a. **Will be made only during regular office hours**, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. **No refills by phone.**
   b. **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. c. **Will not be made** because I suddenly realize I will "run out tomorrow." **I understand I must make an appointment with my doctor in order to get a refill. No exceptions will be made.**

3. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

4. I understand that **if I violate any of the above conditions,** my prescription for controlled substance medications will be terminated **immediately**. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of nonprescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

5. I understand that the **main treatment goal is to manage my medical condition and improve any ability to function and/or work.** In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

6. I understand that the **long-term advantages and disadvantages of narcotics, tranquilizers and barbiturates and other scheduled medication use have yet to be scientifically determined** and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.

I have been fully informed by Dr.Puempel and his staff regarding psychological dependence (addiction) of controlled substance medications, which I understand, is rare. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect and there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I must do so slowly while under medical supervision or I may have withdrawal symptoms. I have read this contract and the same has been explained to me by my provider.

In addition, I fully understand the consequences of violating this agreement.

Patient's Printed Name: ____ Date of Birth: _____________________________

Patient's Signature: ____ Date:____________________________________

Witness Signature: ____ Date: ___________________________________