Custom Made Weight Loss
AND NURSING SOLUTIONS
WEIGHT LOSS SOLUTIONS FOR YOU

Statement of Philosophy

1. Obesity is a chronic disease, which requires a lifelong treatment.

2. Obesity is a disease process with a physiological cause, like diabetes or hypertension. It is **not** a result of "**weakness**" or **"lack of willpower"** on the part of the patient.

3. Obese individuals have a right to healthcare that is safe and fits their lifestyle. It should recognize and respect their individual, physical, social, spiritual, psychological and economic needs.

Nutritional Product Payment Agreement

Payment is necessary for all nutritional products in full prior to services being rendered for the medical weight loss program. The payment is non-refundable and non-transferable. In the event that you are unable to complete the program, you will be able to complete the unused portion at a later date (up to 1 year from your last appointment). **Food is un-exchangeable** due to Department of Health Regulations.

I agree to the above:

X_____

Date: July 18, 2019

Please provide us with the name and telephone number of your primary care physician so that we could keep him/her informed of your progress.

Name _____

Telephone Number_____

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Informed Consent for a Low-Calorie Diet

We want you to know…
When you decided to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight.

The calorie deficit and portion-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974.

Your role…
Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem eating activity and lifestyle patterns so your health care professional can better understand how to help you.

- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phases.

- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your appointments regularly if appropriate, and following your diet and exercise prescription.

- Allow your health care professional to share information with your personal physician.

- Make and keep follow-up appointments with your physician and have any blood test taken or any other diagnostic measure made which your physician may deem necessary during your course of treatment.

- Follow your exercise program within the guidelines given to you by your health care professional and your physician.

- It is vitally important for you to advise the clinic staff on ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the center informed of any questions or symptoms you have, affords the best chance of intervening before a problem becomes serious.

Potential benefits…

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:

- Lower blood pressure, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see our physician as needed to have your need for these medications reassessed. Our health care professional will share your results with your physician on a regular basis so the physician is informed about your progress.

Other benefits my also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits, as well.

Possible side effects…
The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary. In addition it is conceivable other side effects could occur that have not been observed to date.

Reduced Weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. In addition, your body makes some other adjustments in physiology. Some of these are responsible, in some participants for rapid improvements in blood pressure and blood sugar; other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, a slower heart rate , dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

Reduced Potassium Levels. The calorie level you will be consuming is 800 or more calories per day, and it is important that you consume the calories that have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

Gallstones. Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstone (pain, diagnosed stoned and/or surgery) in individuals 30 percent or more over desirable body weight (50 pounds or more overweight) not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 0-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals

entering a weight loss program showed that as many as 1 in 10 had "silent" gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight—especially rapidly—may increase the chances of developing stones or sludge and/or increasing the size of existing stones within the gallbladder. Should any symptoms develop (the most common are fever, nausea and a cramping pain in the right upper abdomen or if you know or suspect that you may already had gallstones), let your physician and health care professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. A drug (Actigall) is currently available that may help prevent gallstone formation during rapid weight loss. You may wish to discuss Actigall with your primary care or weight management physician for more information.

Pancreatitis. Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the right upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long- term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your health care professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

Binge Eating Disorders. Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one

study to increase binge eating episodes temporarily. Several other studies demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The risk of weight regain…
Obesity is a chronic condition, and the majority or overweight individuals who lose weight has a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs.

Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets (including modified fasting) have shown varying results for percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program.

Sudden Death. Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some tiredness,

psychological problems, medication allergies, high blood pressure, rapid heart rate 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.

Informed Consent

Your rights and confidentiality…
You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure the physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

By signing this informed Consent, you state: I understand the information about my treatment in the weight management program offered by the center identified below is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others, I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail, telephone or electronic mail

after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

Resale of Products…
The Center For Medical Weight Loss products purchased through this weight management program, including Multivitamins, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any of The Center For Medical Weight Loss products purchased through this weight management program.

I, the undersigned, have reviewed this information with my health care professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.

X_____ _____
Participant Signature **Date**

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have answered any questions posed by the patient. I believe the patient/relative/guardian fully understands what I have explained and answered.

X_____ _____
Physician Signature **Date**

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ authorize the providers of Custom Made Weight Loss and Nursing Solutions 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 heartbeat 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

QSYMIA PATIENTS- IF YOU ARE PREGNANT WHILE ON THIS MEDICATION IT CAN CAUSE BIRTH DEFECTS. IF YOU ARE PREGNANT YOU SHOULD NOT TAKE THIS MEDICATION. IF YOU BECOME PREGNANT YOU SHOULD STOP TAKING THIS MEDICATION IMMEDIATELY AND CALL OUR OFFICE. IF YOU ARE OF CHILD BEARING AGE, YOU MUST BE ON ACTIVE BIRTH CONTROL.

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 THE DOCTOR or NURSE PRACTICIONER NOW BEFORE SIGNING THIS CONSENT FORM.

X_____ _____

Participant Signature **Date**

VI. HEALTH CARE PROVIDERS 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.

X_____ _____

Physician's Signature & Date **Date**

Patient Registration

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Former Name: _____ **DOB:** _____ **SSN#:** _____

Sex: ☐ Female ☐ Male **Marital Status:** ☐ Single ☐Married ☐Divorced ☐Widowed ☐ Legally Separated

Ethnicity: _____ **Race:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Extension:** _____

Cell Phone: _____ **Cell Phone Carrier:** _____ **Can We Text You?** ☐Yes ☐No

Which phone would you prefer us to use: ☐Home ☐Cell ☐Work

Can we leave a voice mail? House- ☐Yes ☐No **Cell-** ☐Yes ☐No **Work-** ☐Yes ☐No

Can we leave a message with a family member? ☐Yes ☐No

Email Address: _____ **Can we email you?** ☐Yes ☐No

Pharmacy: _____ **City:** _____ **Phone:** _____ - _____ - _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

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New Patient Questionnaire

Name: _____ **Email:** _____

How did you hear about our practice? _____

What is your goal weight? _____

How long do you expect it to take to reach that goal? _____

Have you been overweight your entire life? ☐Yes ☐No

If no, have you been overweight your entire adult life? ☐Yes ☐No

Have you lost weight dieting in the past? ☐Yes ☐No

If yes, which type of diet worked for you? _____

Are you allergic to any type of food? ☐Yes ☐No

Do you exercise? ☐Yes ☐No If yes, how often and for how long? _____

Are you willing to make permanent lifestyle changes to maintain a healthy weight once you get to your goal?
☐Yes ☐No

Please list any obstacles you've encountered with prior weight loss plans

1. _____
2. _____
3. _____
4. _____

HIPAA Information and Consent Form

Patient Name: _____ Date: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature:

Date:

_____ _____

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Name: _____ Date: _____

Primary Care Doctor: _____ Phone/Fax: _____ (if known)

How did you hear about us? ☐ Online ☐ Current Patient (name) _____ ☐Other

Current Medications:

Drug Name	Strength (mg)	How many times per day

(Put additional medications on back of this page)

Medical Problems Diagnosed by a Doctor/Hospital:

Year Diagnosed	Problem

(Put additional medical problems on back of this page)

Allergies:	Name/Type	Reaction
Medications		
Food		
Other		

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Surgical History: (check all appropriate)

☐ Gall Bladder ☐ Gastric Bypass/Band ☐ Appendix ☐ Heart ☐ Lung

☐ Orthopedic ☐ Brain ☐ Spine ☐ Liver

☐ Other: _____

Overnight Hospitalizations for serious illness: (excluding childbirth)

☐ No ☐ Yes (If yes, please list) _____

Family History: (parents, siblings, children only)

Cardiac Disease- ☐ Yes ☐ No Cancer ☐ Yes ☐ No

Pulmonary Disease- ☐ Yes ☐ No Thyroid Disease- ☐ Yes ☐ No

Other: _____

Social History: (check all appropriate)

Cigarette Smoking	Alcohol	Drugs
☐Yes ☐No ☐Quit: When_____	☐Yes ☐No ☐Quit: When_____	☐Yes ☐No

Exercise: ☐Yes ☐No _____ Times/Week

Consent to Photograph

I, _____, give consent that Custom Made Medical Weight Loss can photograph me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis and treatment while a patient; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Custom Made Medical Weight Loss and its professional staff; and (c) publishing the results of my treatment on Custom Made Medical Weight Loss's website which, in this particular case, required me to sign the HIPAA authorization form.

The purpose of this form is to obtain my prior written consent so that Custom Made Medical Weight Loss may photograph me for one or more of the following purposes listed below for which I do hereby consent.

(Initial all purposes that apply):

_____ Use or disclosure of image for identifying me as a patient, INNER OFFICE ONLY!

_____ Use or disclosure of image for conducting educational training

_____ Use or disclosure of image for marketing or advertising purposes and patient education

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of medicine, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.

I also agree to sign the HIPAA authorization form which permits Custom Made Medical Weight Loss to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.

_____ _____

Patient (or Patient's Legal Representative) Signature Date