Idaho Weight Loss
Over a half million pounds lost.

PLEASE PRINT ALL INFORMATION CLEARLY: Today's Date: _____

Full Name _____ Date of Birth _____

Street Address _____ City/State/Zip _____

Preferred Phone _____ Other Phone _____

Occupation _____ E-Mail _____

Spouse's Name _____ Primary Care MD _____

Preferred Pharmacy _____

Age_____ Height_____ Sex_____

Do you now or have you ever been treated for any of the following:

NO	YES	
		High Blood Pressure
		Heart Disease
		Diabetes
		Thyroid Disorder
		Hormones or Birth Control
		High Cholesterol
		Depression
		Sleep Disorder
		Lung Disease e.g. Asthma
		Glaucoma
		Any other regular medicines

PLEASE LIST **ALL** CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List any major surgeries: _____

_____

List any serious illnesses _____

Any family history of: Heart Disease _____ Stroke _____ Diabetes _____ Thyroid Disorder _____

Cancer _____ High Cholesterol _____ Obesity _____ Sudden/Unexplained Death <40y.o. _____

Have you ever had or been treated for alcohol or other substance abuse/dependence? _____

Do you use any tobacco/nicotine products? _____

Goal Weight _____ What age were you last at that weight? _____ Max Weight(not pregnant) _____

Any previous prescription weight loss medicines? _____

Do you exercise regularly? _____ How often? _____ Any problems with exercise?_____

Do you eat nutritiously? _____ Excessively? _____ Do you count calories? _____

Have you been overweight all your life? _____ If not, how long? _____

Menses regular? _____ # of Children _____ Are you pregnant? _____

Any allergies to medicines? Please list _____

Do you need a Child Proof Container? **NO** ☐ **YES** ☐

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Informed Consent for Treatment

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the medicines and length of medicine usage may be used in an "off label" manner. This means the doctor may be using the medicines in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, lifestyle patterns, medication or drug usage (including any weight loss meds, DEA controlled meds, stimulant type medications, and any or all habit forming drugs) to help us best help you.
2. Devote the time and effort necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal physician if necessary
4. Make and keep follow-up appointments and allow necessary blood tests as needed.
5. Advise the clinic staff and Dr. of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a personal physician before beginning this program.

Possible Side Effects

1. **Reduced weight.** Reducing your caloric intake may give a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation or diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above, dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure.
2. **Reduced potassium levels or other electrolyte abnormalities.** These can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We may need to follow your levels with occasional blood testing.
3. **Gallstones.** Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. Notify your doctor or us if you develop symptoms of gallstones including, abdominal pain, fever nausea and vomiting. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or surgery to remove the gall bladder.
4. **Pancreatitis**. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight

loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs. You should take precautions to avoid becoming pregnant during weight loss.

6. **Sudden death**. Patients with obesity especially those with associated high blood pressure, diabetes, heart disease have a higher risk of sudden death and development of a serious potentially fatal disease Primary Pulmonary Hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.

7. **Risk of weight regain.** Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued.

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Your Rights and Confidentiality

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained **(HIPAA)**

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

Uses and Disclosures of Information that We May Make Without Written Authorization: Treatment, Payment, Healthcare operations, required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody.

Uses and Disclosures of Information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. If you object, please notify the Privacy Contact identified at the end of this document

Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Your Rights Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates. **Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Entities to Whom This Notice Applies: This notice applies to Obesity Medicine Specialists of Idaho.

Privacy Officer Contact: If you have any questions about this Notice, to request a copy of the complete notice or if you want to object to or complain about any use of disclosure or exercise any right as explained above, please contact our Privacy Officer, Deb Mabbutt PA-C 801 N Stilson Rd #200 Boise, ID 83703 208-343-3652

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

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Office Policies

MISSED APPOINTMENT POLICY

In an effort to better serve our patients, we ask that you give a minimum of 24 hours notice if you are unable to keep your appointment. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you, and your health care is important to us.

If you do not cancel your appointment with at least 24 hour advance notice or you fail to keep your appointment, you may receive a charge of $50.00.

An excessive amount of missed appointments could result in being discharged from our practice.

LATE POLICY

If you are late for your appointment, the receptionist will do the following:

- Check with the provider or staff and see if you can be seen without delaying other scheduled appointments.
- Reschedule for another day
- Reschedule same day for a different time

PAYMENT POLICY

All payment is due at time of service. We accept cash, check, Visa, Mastercard, Discover, or American Express.

We can provide you with paperwork to submit to your insurance for possible reimbursement , but we do not accept insurance. **Please note; our services CANNOT be submitted to Medicare.**

CELL PHONES AND PAGERS

To ensure that you have uninterrupted, quality time with your health care provider during your examination, we ask that you turn off your cell phone or your pager when you enter the examination room.

Thank you,

Print Name_____

Signature_____ **Date**_____

Various researchers have estimated that one-fourth (1/4) of the United States population is hypothyroid, possibly as high as 40% may be hypothyroid.

Please check if you have any of the following telltale physical and/or emotional signs of hypothyroidism:

Name_____

____1. Weakness
____2. Dry, coarse skin
____3. Tired
____4. Slow speech
____5. Swelling of face and eyelids
____6. Coldness and cold skin
____7. Diminished sweating
____8. Thick tongue
____9. Coarse hair
____10. Pale skin
____11. Constipation
____12. Gain in weight
____13. Loss of hair
____14. Labored, difficult breathing
____15. Swollen feet
____16. Hoarseness
____17. Loss of appetite
____18. Excessive/painful menstruation
____19. Nervousness
____20. Heart palpitation
____21. Brittle nails
____22. Slow movement
____23. Poor memory
____24. Emotional instability
____25. Depression
____26. Headaches

_____ PLEASE CHECK HERE IF NONE OF THE ABOVE APPLY

HOW DID YOU HEAR ABOUT IDAHO WEIGHT LOSS?

Thank you for coming to see us. Please share how you found us. Your name please _____

Circle any that apply:

1. **I was a previous patient.**
2. **My doctor's office referred me to you. Dr or PA name _____**
3. **I found you in the Yellow Pages.**
4. **I found you in a newspaper/magazine. Which one?**
   Idaho Statesman____ Idaho Press Tribune____ Idaho Health Magazine____ Other____
5. **I saw your web page on the Internet.**
6. **I heard a radio advertisement.**
7. **Facebook_____Twitter_____Pinterest_____Other_____ 8. Television ad or program. Which channel? _____**
9. **Drove by and saw the sign.**
10. **Billboard**
11. **My family member, friend or co-worker who is currently a patient here inspired me to start. We will give them $50 off their next visit to thank them.**
    Their name please _____
12. **Other_____**

Opt in for text reminders

Idaho Weight Loss is happy to send you unencrypted reminder texts for your appointment. If this is something you are interested in receiving, please provide us with the phone number at which you choose to receive your text.

Phone number_____

Signature_____Date_____

Staff initial_____

*If you choose to have a reminder phone call instead of a text, please inform a staff member.

Thank you,

Idaho Weight Loss