Texas Medical Weight Loss Clinic

Patient Information:

How did you hear about us? ____

Patient Name: (Last)______________________(First)____________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ______________________________ State: __________ Zip: ___________

Home Phone: _________________________Beeper/Cellular: ________________

Email address: ________________________

Birth date: ____________________________Age: _______Sex: M F

Employment Information:

Patient Employer: ______________________ Occupation: ___________________

Employer Address: ____

City: ______________________________ State: __________ Zip: ___________

Work phone No: ________________________Ext. __________________________

Social Security: ________________________Drivers License: ________________

In Case of Emergency:

Name: _________________________Relationship: __________ Phone: ___________

Patient's Spouse: ____________________________________ Phone: ___________

Family Physician: ____________________________________ Phone: ___________

Referred by: ____

Financial Policy:

Thank you for selecting Dr. Zafar and/or Dr. Aziz for your weight loss needs. We are honored to be of service to you. This is to inform you of our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, Care Credit, Flex Spending Accounts, cash and checks. A $25 fee will be charged for any returned checks.
All pre-paid treatment regimens are non-refundable. In the event that you are unable to complete a pre-paid treatment regimen, you could finish the treatment at a later date. (Up to one year from your last appointment)

I have read and understand all of the above and have agreed to these statements.

______________________________ ______________________________
Patient's Signature Date

Medical History Form

Name: ____ Age:_________ Sex: M F

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? ____

3. Are you taking any medications at the present time? Yes No
   What: ______________________________________ Dosages: __________________
   What:______________________________________ Dosages: __________________
   What: ______________________________________ Dosages: _________________

4. Any allergies to any medications? Yes No
   ____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age? ____________

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: ____________________________

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Last menstrual period: ____
    Hormone Replacement Therapy: Yes No
    What: ____
    Birth Control Pills: Yes No
    Type: ____
    Last Check Up: ____

13. Serious Injuries: Yes No
    Specify: ____ Date: ________

14. Any Surgery: Yes No
    Specify: ____ Date: ________
    Specify: ____ Date: ________

15.Family History:

Age Health Disease Cause of Death Overweight?

Father: ____

Mother: ____

Has any blood relative ever had any of the following?

Glaucoma:	Yes	No	Who: ______________________
Asthma:	Yes	No	Who: ______________________
Epilepsy:	Yes	No	Who: ______________________
High Blood Pressure	Yes	No	Who: ______________________
Kidney Disease:	Yes	No	Who: ______________________
Diabetes:	Yes	No	Who: ______________________
Tuberculosis:	Yes	No	Who: ______________________
Psychiatric Disorder	Yes	No	Who: ______________________
Heart Disease/Stroke	Yes	No	Who: ______________________

Past Medical History: (check all that apply)

_______ Polio	_______ Measles	_______ Tonsillitis
_______ Jaundice	_______ Mumps	_______ Pleurisy
_______ Kidneys	_______ Scarlet Fever	_______ Liver Disease
_______ Lung Disease `	_______ Whooping Cough	_______ Chicken Pox
_______ Rheumatic Fever	_______ Bleeding Disorder	_______ Nervous Breakdown
_______ Ulcers	_______ Gout	_______ Thyroid Disease
_______ Anemia	_______ Heart Valve Disorder	_______ Heart Disease
_______ Tuberculosis	_______ Gallbladder Disorder	_______ Psychiatric Illness
_______ Drug Abuse	_______ Eating Disorder	_______ Alcohol Abuse
_______ Pneumonia	_______ Malaria	_______ Typhoid Fever
_______ Cholera	_______ Cancer	_______ Blood Transfusion
_______ Arthritis	_______ Osteoporosis	_______ Other: ______________

Nutrition Evaluation:

1. Present Weight: __________ Height (no shoes): ___________ Desired Weight: _____________

2. In what time frame would you like to be at your desired weight? ________________________________

3. Weight at 20 years of age: ________ Weight one year ago: _______________

4. What is the main reason for your decision to lose weight? ______________________________________

5. When did you begin gaining excess weight? (Give reasons, if known): __________________________

   ____

6. What has been your maximum lifetime weight (non-pregnant) and when?________________________

7. Previous diets you have followed: Give dates and results of your weight loss:

   _______________________________________ ____

8. Is your spouse, fiancee or partner overweight? Yes No

9. By how much is he or she overweight? ____

10. How often do you eat out? ____

11. Food allergies: ____

12. Do you drink coffee or tea? Yes No How much daily? ______________________________

13. Do you drink cola drinks? Yes No How much daily? ______________________________

14. Do you drink alcohol? Yes No

What? ______________________ How much? ____________________ Weekly? __________

15. When you are under a stressful situation at work or family related, do you tend to eat more? _______

16. Smoking Habits: **(answer only one)**

____ You have never smoked cigarettes, cigars or a pipe.
____ You quit smoking _____ years ago and have not smoked since.
____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
____ You smoke 20 cigarettes per day (1 pack).
____ You smoke 30 cigarettes per day (1-1/2 packs).
____ You smoke 40 cigarettes per day (2 packs).

17. Describe your usual energy level: ____

18. Activity Level: **(answer only one)**
____ Inactive—no regular physical activity with a sit-down job.
____ Light activity—no organized physical activity during leisure time.
____ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, Swimming or cycling.
____ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
____ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

19. Behavior style: **(answer only one)**
____ You are always calm and easygoing.
____ You are usually calm and easygoing.
____ You are sometimes calm with frequent impatience.
____ You are seldom calm and persistently driving for advancement.
____ You are never calm and have overwhelming ambition.
____ You are hard-driving and can never relax.

20. Please describe your general health goals and improvements you wish to make: _________________

____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

X ____
(Physician Sign)

Weight Loss Program Consent Form

I ______________________________________ authorize Dr.
and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: **Time:**

Witness: ______________________________

Patient: ______________________________
(Or person with authority to consent for patient)

______________________________ ______________________________

Appointment Cancellation Policy

As a result of not having any available appointments in our schedule and in order to best service our patients, the following policy is necessary:

There will be a $30 charge if you fail to cancel your scheduled appointment in advance. You will be billed $30 on the day of your visit if you fail to cancel your appointment prior to the scheduled time.

I agree to the above:

X ____

Name

Date: ______________________________

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 unexchangeable due to Department of Health Regulations.

I agree to the above:

X ____

Name

Date: ______________________________

Texas Medical Weight Loss Clinic
Privacy Practices
and
HIPAA Policy Statement

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

During your treatment at **Texas Medical Weight Loss Clinic**, and members of its staff may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by
Texas Medical Weight Loss Clinic. We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

Your medical information may be used and disclosed for the following purposes:

Treatment: We may use your information to provide, coordinate, and manage your care and treatment. For example, a **Texas Medical Weight Loss Clinic** staff member may share your medical information with another health care provider for a consultation or a referral.
Payment: We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company, or another third party. For example, we may need to give your health plan information about treatment you received at **Texas Medical Weight Loss Clinic** so your health plan will pay us or reimburse you for the treatment.
Health Care Operations: We may use and disclose medical information about you for **Texas Medical Weight Loss Clinic** health care operations. Health care operations are the uses and disclosures of information that are necessary to run **Texas Medical Weight Loss Clinic** and to make sure that all of our customers receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you.
Appointment Reminders and Other Health Information: We may use your medical information to send you reminders about future appointments. We may also contact you with information about new or alternative treatments or other health care services.
To People Assisting in Your Care. **Texas Medical Weight Loss Clinic** will only disclose medical information to those taking care of you, helping you to pay your bills, or other close family members of friends if these people need to know this information to help you, and then only to the extent permitted by law. We may, for example, provide limited medical information to allow a family member to pick up a hearing device for you. If you are able to make your own health care decisions, **Texas Medical Weight Loss Clinic** will ask your permission before using your medical information for these purposes. If you are unable to make health care decisions, **Texas Medical Weight Loss Clinic** will disclose relevant medical information to family members or other responsible people if we feel it is in your best interest to do so, including in an emergency situation.
Research: Federal law permits **Texas Medical Weight Loss Clinic** to use and disclose medical information about you for research purposes, either with your specific, written authorization or, where allowed by state law, when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. If required to do so by applicable law, we will obtain your consent before we disclose your health information to an outside researcher.

To Business Associates: Some services are provided by or to **Texas Medical Weight Loss Clinic** through contracts with business associates. Examples include **Texas Medical Weight Loss Clinic's**, attorneys, consultants, collection agencies, and accreditation organizations. We may disclose information about you to our business associate so that they can perform the job we have contracted with them to do.

In all of the situations described above, where required to do so by law, **Texas Medical Weight Loss Clinic** will obtain your written permission prior to disclosing your health information,

Your medical information may be released in the following special situations:

1. We may also use or disclose your information, without your permission, for the following purposes to the extent permitted or required by law:
2. Under emergency conditions, to government or other groups assisting in emergencies or disasters;
3. When required by law;
4. For public health activities, including, without limitation, to report disease and vital statistics, child abuse, and adult abuse or neglect or domestic violence;
5. For health oversight activities, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies;
6. For judicial and administrative proceedings;
7. To avert a serious threat to health or safety;
8. To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying and locating suspects or other persons.
9. For certain specialized government functions, such as military discharge;
10. To the military, to federal officials for lawful intelligence, counterintelligence, national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody;
11. As authorized by the state's worker's compensation laws.

In all of the situations described above, where required to do so by law, **Texas Medical Weight Loss Clinic** will obtain your specific written permission prior to disclosing HIV-related information, mental health records, drug or alcohol abuse records, or any other type of record given explicit additional protections under applicable state law.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and receive a copy of your medical information that is used to make decisions about your care. Usually, this includes medical and billing records maintained by **Texas Medical Weight Loss Clinic**.

If you wish to inspect and copy medical information, you must complete and return a Request to Inspect and Copy Form (a copy of which is available upon request). If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request, to the extent permitted by state and federal law. We may deny your request to inspect and copy your information in certain very limited circumstances. For example, we may deny access if your physician believes it will be harmful to your health, or could cause a threat to others. If you are denied access to medical information, you may request that the denial be reviewed. Another health care provider chosen by **Texas Medical Weight Loss Clinic** will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request Amendment: If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change the information. You have the right to request an amendment for as long as the information is kept by or for **Texas Medical Weight Loss Clinic**. To request a change to your information, you must complete and return a Request for Amendment Form (a copy of which is available upon request). In addition, you must provide a reason that supports your request.

Texas Medical Weight Loss Clinic may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by **Texas Medical Weight Loss Clinic**, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the medical information kept by or for **Texas Medical Weight Loss Clinic**;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

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. This list will not include disclosures for treatment, payment, and health care operations; disclosures that you have authorized or that have been made to you; disclosures for facility directories; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement with custody of you; disclosures that took place before April 14, 2003; and certain other disclosures.

To request this list of disclosures, you must complete and return a Request for Accounting of Disclosures Form (a copy of which is available upon request). Your request must state a time period for which you would like the accounting. The accounting period may not go back further than six years from the date of the request, and it may not include dates before April 14, 2003. You may receive one free accounting in any 12-month period. We will charge you for additional requests.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could ask that we not use or disclose information about treatment that you received to other health care providers or to your insurance company. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must complete and return a Request for Restrictions Form (a copy of which is available upon request).

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you only at work or only by mail. To request confidential communications, you must complete and return a Confidential Communication Request Form (a copy of which is available upon request). We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask us to give you a copy of this notice any time.

Texas Medical Weight Loss Clinic Privacy Practices and HIPAA Policy Statement (cont.)

Changes to This Notice

The effective date of this notice is April 14, 2003. 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 about you, as well as any information we receive in the future. If the terms of this notice are changed, **Texas Medical Weight Loss Clinic** will provide you with a revised notice upon request, and we will post the revised notice on our website and in designated locations at **Texas Medical Weight Loss Clinic**.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with **Texas Medical Weight Loss Clinic**, please complete and return a Complaint Form (a copy of which is available upon request) or contact our Compliance Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Except as described above, **Texas Medical Weight Loss Clinic** will not use or disclose your protected health information without a specific written authorization from you. If you provide us with this written authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent we have already relied on your authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

Texas Medical Weight Loss Clinic

Notice of Privacy Practices and HIPAA Policy Statement

Acknowledgment Of Receipt Form

Name: ___________________________________ Date of Birth:___________
I have received a copy of the Wellness Concepts, PA Privacy Practice Policy.

Signature:______________________________________ **Date: _________________**
Individual or Personal Representative with legal authority to make healthcare decisions

If signed by a Personal Representative:
Print Name____Role:_________________
(Parent, guardian, etc.)

Witness: _____________________________________ Date:__________________

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the personal representative. ***If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it***.

Notice of Privacy Practices given to the individual on_____________ by ________________

- ❑ Face to face meeting
- ❑ Mailing
- ❑ Email
- ❑ Other:______________________

Reason Individual or Personal Representative did not sign this form:

- ❑ Individual or Personal Representative chose not to sign
- ❑ Individual or Personal Representative did not respond after more than **one** attempt
- ❑ Physically Unable:____________________________________
- ❑ Other:_____________________________________

Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- ☐ Face to face presentation(s)____
- ☐ Telephone contact(s)____
- ☐ Mailing(s) ____
- ☐ Email____
- ☐ Other____

Staff Signature:____ Date:_____________

Staff Printed Name: ________________________________

This form must be retained for a period of at least six years in the appropriate record.