Texas Medical Weight Loss Clinic

Personal Information:

How did you hear about us?______________________________

Name: (Last)________________ (First)________________ (MI)_____

Address:______________________________

City:________________ State:__________ Zip:__________

Home Phone:________________ Cell:________________

Email address:______________________________

Birth Date:________________ Age:__________ Sex: M F

In Case of Emergency:

Name:________________ **Relationship:**__________ **Phone:**__________

Family Physicain:

Name:________________ Phone:________________

Financial Policy:

Thank you for selecting the Texans Medical Weight Loss Clinic 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, Flexible Spending Accounts, cash and checks. A $25 fee will be charged for any returned checks.

All prepaid treatment regimens are non-refundable. In the event that you are unable to complete a prepaid treatment regimen, you can finish the treatment at a later date. (Up to one year after your last appointment.)

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

____________________________ ________________

Signature Date

Medical Questionnaire

Name: ____ Date: _____________

1. Are you under a doctor's care at the present time? YES NO
   If yes, for what? ____

2. Are you taking any medications at the present time? YES NO
   Med: ___________________________________ Dosage: ________________
   Med: ___________________________________Dosage: ________________
   Med: ___________________________________Dosage: ________________
   Med: ___________________________________Dosage: ________________
   Med: ___________________________________Dosage: ________________

3. Do you have any allergies to medications? YES NO
   If yes, list the medication and your allergic reaction:

   ____

4. Please check all that apply:

   ___ anemia
   ___ drug abuse
   ___ heart valve disorder
   ___ eating disorder
   ___ osteoporosis
   ___ liver disease
   ___ thyroid disease
   ___ heart disease
   ___ psychiatric illness
   ___ alcohol abuse
   ___ chest pain
   ___ swollen feet
   ___ diabetes
   ___ migraines

5. Please describe your general health goals and improvements you wish to make:
   ____
   ____
   ____

6. Please list the pharmacy name, location and phone number that you prefer to use.
   Name: ____
   Location: ____
   Phone : ____

Weight Loss Program Consent Form

I authorize Dr. Zahid Zafar and whomever he designates as his assistant, 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. 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 the 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 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 confirm that I am not pregnant or trying to get pregnant at this time. I understand that taking medications prescribed by Texans Medical Weight Loss Clinic could be harmful or even fatal to a fetus. I will not try to get pregnant while taking any prescribed medications by Texans Medical Weight Loss Clinic and I agree to hold Texans Medical Weight Loss Clinic harmless from any claims or lawsuits if I should get pregnant while taking said medications.

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 should I not understand. My questions have been answered to my complete satisfaction. I 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 our staff now before signing this consent form.

Date:____________________________ **Time:**____________________________

Witness:__________________________ **Patient:**____________________________

In order to provide you with the best possible care, we regularly communicate through convenient text messages to our patients about their health care and the products and services we offer. You will receive text messages for appointment reminders, information about your healthcare treatment and any specials we may run on products and services we offer.

We look forward to providing better and more convenient communications with you via text messaging. Our goal is to provide you with relevant and useful information about your healthcare and the products and services we offer for improving your health. Thank you!

I consent to communicate via text message with Texans Medical Weight Loss Clinic YES or NO

____

Printed Name

____

Signed Name

Texans 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 Texans Medical Weight Loss Clinic (TMWLC) 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 TMWLC. We are required by law to make sure that medical information that identifies you is kept private, post this notice of our legal duties and privacy practice 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 TMWLC staff member may share your medical information with another health care provider for a consultation or 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 TMWLC so your health plan will pay us or reimburse you for the treatment.

Healthcare Operations: We may use and disclose medical information about you for TMWLC healthcare operations. Healthcare operations are the uses and disclosures of information that are necessary to run TMWLC 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 healthcare services.

To people assisting in your care. TMWLC will only disclose medical information to those taking care of you, helping you to pay your bills, or other close family members or friends if these people need to know the 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 healthcare decisions, TMWLC will ask your permission before using your medical information for these purposes. If you are unable to make healthcare decisions, TMWLC 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 an emergency situation.

Research: Federal law permits TMWLC 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 TMWLC through contracts with business associates. Examples include TMWLC 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, TMWLC will obtain our written permission prior to disclosing your health information.

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

1. We may 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 proceeding.
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 lawful custody.

11. As authorized by the state's workers compensation laws.

In all of these situations described above where required to do so by law, TMWLC will obtain your specific written permission prior to disclosing HIV-related information, mental health records, drug or alcohol substance abuse records, or any other type of record given explicit additional protection sunder 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 TMWLC.
If you wish to inspect and copy medical information, you must complete and return a request to inspect and copy form. If you request a copy of the information we may charge a fee for the cost 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 TMWLC 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 TMWLC. 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.
TMWLC may deny your request for an amendment if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by TMWLC, 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 TMWLC
3. Is not part of the information which you would be permitted to inspect or copy
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 the 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 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 the 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.

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, TMWLC will provide you with a revised notice upon request, and we will post the revised notice on our website and in designated locations at TMWLC.

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 TMWLC, 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, TMWLC 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 also 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 provide to you.

Texans Medical Weight Loss Clinic

Notice of Privacy Practices and HIPAA Policy Statement

Acknowledgement of Receipt Form

Name: ______________________________ **Date of Birth:** ____________________

I have read or received a copy of the TMWLC Privacy Practice Policy

Signature: ______________________________ **Date:** ____________________

If signed by a Personal Representative:

Print Name: ______________________________ **Role:** ____________________

(Parent, Guardian, etc.)

Staff Signature: ______________________________ **Date:** ____________________

Staff Printed Name: ______________________________