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

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 : _____

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: _____

TEXAS MEDICAL
Weight Loss
CLINIC

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

_____

Date

Cancellation Policy

In effort to keep our schedule fluent and have available appointment slots for people wanting to come in, a 24 hour cancellation policy is in place. Please provide 24 hour notice if you are unable to make your scheduled appointment time. The $35 fee will be automatically added to your next visit fee if a 24 hour cancellation notice is not given.

By signing this form, I acknowledge that I understand Texans Medical Weight Loss appointment cancellation policy and that I must give a 24 hour notice in order to avoid a $35 fee being added to my next office visit.

_____

Print Name

_____

Sign Name

_____

Date

Texans Medical Weight Loss Clinic

Program Consent

I authorize Texans Medical Weight Loss Clinic, Dr. Zahid Zafar and his Nurse Practitioner staff as well as his office staff 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, may involve the use of appetite suppressant medications, GLP-1 medications and Vitamin B-12 supplements. I further understand that if appetite suppressant medications and or GLP-1 medications are used, they may be used "off label" or for durations exceeding those recommended on the medication package insert. I understand 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 cardiovascular 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, lifelong condition that may require permanent changes in eating habits and behaviors to be treated successfully.

I confirm that I am neither pregnant nor trying to become 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 realize I should not sign this form if all items have not been explained to me should I not understand. I have been given all the time I need to read and understand this form and my questions have been answered to my complete satisfaction.

_____

Print name

_____

Sign name

_____

Date

Texans Medical Weight Loss Clinic

Controlled Substances Agreement

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that you may be prescribed
by the providers at this clinic. The goal is to treat you safely with these medications and also to prevent abuse of these medications. This agreement is also set forth to assist you and your provider to comply with the law regarding
controlled pharmaceuticals.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety
and legal reasons. Therefore, the following polices are agreed to by you, the patient, to help maintain safety and provide
quality, effective care.

I agree to the following:

• I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's
medication.

• I will not increase my medication until I speak with my provider. If I do so on my own, the provider may taper and d/c
medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period
of time.

• My prescription for a
controlled substance may not be replaced if lost/stolen.

• Renewals are contingent on keeping scheduled appointments. Early refills will not be given.

• I will not obtain any controlled medications to treat the same symptoms from any other doctor.

Should the need arise to change pharmacies, our office
must be informed.

I understand that if I break this Agreement, my provider may stop prescribing me certain medications and /or release me from
the practice. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding
this agreement have been adequately answered. By signing this form, I agree to uphold the requirements set herein.

_____

Print name

_____

Sign name

_____

Date

Texans Medical Weight Loss Clinic

Vitamin Injection Consent Form

Vitamin B12 with Amino Acids Injection Information

This medication is given by injection into a muscle. We have discussed schedule of injections with you. Side effects from vitamin injections are rare, but may include; mild diarrhea, itching, temporary feeling of warmth and pain at the injection site, muscle atrophy at the injection site, hypopigmentation or infection. An allergic reaction to this vitamin is unlikely, but seek immediate medical attention should

Should you opt to take injections home for self- administration, you agree that the responsibility for your health is your own. You agree that you have received instruction on how to administer an intramuscular injection, you feel comfortable with the procedure and you will not hold Texans Medical Weight Loss Clinic liable for any issues that arise from the self- administration of the injection including but not limited to the above listed possible side effects.

Contraindications

- Sensitivity to cobalt and/or cobalamin
- Chronic liver and/or kidney dysfunction
- Leber's disease, a hereditary optic nerve atrophic condition

I intend this consent form to cover the entire course of my treatment. I understand that I am free to withdraw my consent and to discontinue participation at any time.

Patient Printed Name: _____

Patient Signature: _____

Date of Birth: _____

Date: _____

Texans Medical Weight Loss Clinic
Telehealth Consent

- You will need access to the certain technological services and tools to engage in Telehealth-based services with your provider.
- Telehealth has both benefits and risks, which you and your provider will be monitoring as you proceed with your visit.
- It is possible that receiving services by Telehealth will turn out to be inappropriate for you, and that you and your provider may have to cease work by Telehealth-based services.
- You can stop your visit by Telehealth at any time without prejudice.
- You will need to participate in creating an appropriate space for your Telehealth health sessions · You will need to participate in creating a quiet space so the provider can hear you, you agree not to be driving in your car, and you agree to be in an appropriate sitting position to take your blood pressure reading.
- Your provider follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy

What is Telehealth?

- Telehealth means the provisioning of health services by a provider to a recipient of services where each person is in separate location, and the services being delivered are over electronic media.
- Services delivered via Telehealth rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, telephony, email, text messaging, virtual environments and others. Our Practice uses HIPAA compliant Audio & Video features.
- You will need access to the Internet, a Microsoft Windows or Apple Mac compatible computer that has a built-in or attached video camera and microphone.

If you have any questions or concerns about the above tools, please address them directly to your provider so you can discuss their risks, benefits, and specific application to your treatment.

Benefits and Risks of Telehealth

Receiving services via Telehealth allows you to:

- Receive services when you are unable to travel to the service provider's office
- Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.
- The unique characteristics of Telehealth health media may also help some people make improved progress on health goals that may not have been otherwise achievable without Telehealth health.

Receiving services via Telehealth has the following risks:

Telehealth health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

- Internet connections and cloud services could cease working or become too unstable to use
- Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of Telehealth health-based service delivery.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.

Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly or using the most effective tools. Your provider may also be unable to help you in-person.

There may be additional benefits and risks to Telehealth health services that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services. Your provider will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Assessing Telehealth's Fit for You

Although it is well validated by research, service delivery via Telehealth health is not a good fit for every person. Your provider will continuously assess if working via Telehealth health is appropriate for your case. If it is not appropriate, your provider will have you come into the office for your care.

Please talk to your provider if you find the Telehealth health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the Telehealth health medium seems to be causing problems in receiving services. Raising your questions or concerns will not, by itself, result in termination of services. Bringing your concerns to your provider is often a part of the process.

You also have a right to stop receiving services by Telehealth health at any time without prejudice. If your provider also provides services in-person and you are reasonably able to access the provider's in-person services, you will not be prevented from accessing those services if you choose to stop using Telehealth health.

Your Telehealth Health Environment

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people and pets. You must not be in your car. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. It should be free of other distractions such as doorbells or telephones ringing. If you are unsure of how to do this, please ask your provider for assistance.

Our Communication Plan

At our first session, we will develop a plan for backup communications in case of technology failures. In addition to those plans, your provider has the following policies regarding communications:

- The best way to contact your provider between sessions is by telephone or text messaging. If contacting via text messaging be sure to state your name within the body of the message.
- Your provider will respond to your messages within 24-48 business hours.Please note that your provider may not respond at all on weekends or holidays. Your provider may also respond sooner than stated in this policy. That does not mean they will always respond that quickly.

Please note that all textual messages you exchange with your provider, e.g. emails and text messages, my not be a secure method of communication and will become a part of your health record.

Your provider may coordinate care with one or more of your other providers. Your provider will use reasonable care to ensure that those communications are secure and that they safeguard your privacy.

Your Security and Privacy

Except where otherwise noted, your provider employs software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your health care services are not lost or damaged.

As with all things in Telehealth, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with your provider, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that your provider has supplied for communications.

Recordings

Please do not record video or audio sessions without your provider's consent. Making recordings can quickly and easily compromise your privacy and should be done so with great care. Your provider will not record video or audio sessions.

By signing this consent you agree to the information contained herein.

_____

Print name

_____ _____

Sign name Date