WEIGHT NO MORE - MEDICAL HISTORY

First Name	MI	Last Name	Date of Birth

Physical Address	City	State	Zip
Mailing Address	**City**	**State**	**Zip**

Home Phone	Work Phone	Cell Phone	Ok to Contact? If yes, where?
Height	**Weight**	Marital Status	Do you want to receive blogs? ☐ Yes ☐ No
Email Address		How did you hear about us?	
Occupation			

Family Physician	Phone No	Last Exam
Permission to consult with your doctor? ☐ Yes ☐ No	If yes, sign here:	

Do you have any current medical problems? (please explain)

List any significant past medical problems: (your medical history is on the back of this sheet)

In your family is there a history of: ☐ Heart Problems ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Kidney Disease ☐ High Blood Pressure ☐ Endocrine Disorders ☐ Or anything else you think might be important?

Weight problem in the family? ☐ Yes ☐ No

Have you ever had thyroid, cholesterol, or triglyceride tests? ☐ Yes ☐ No If so, when and explain results:

Do you take any medications? ☐ Yes ☐ No Please List if YES:

_____

_____

_____

Allergies to any mediations?

Have you ever taken prescription or non-prescription meds/products for appetite control? ☐ Yes ☐ No
If yes, when and what?

Do you have any history of Thyroid problems? Have you taken a Thyroid Hormone or Cortisone? ☐ Yes ☐ No
If so, please explain:

History or any of the following? If Yes, Please Explain

Anemia ☐ Yes ☐ No Cancer ☐ Yes ☐ No Chronic Fatigue or Weakness ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No Glaucoma ☐ Yes ☐ No
If YES, Please Explain:

Chest Pain ☐ Yes ☐ No Heart Attack ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No Irregular Heart Beat ☐ Yes ☐ No Palpitations ☐ Yes ☐ No
If YES, Please Explain:

Have you ever been given an EKG? ☐ Yes ☐ No If so, when and why?

Shortness of breath on mild exertion or when lying down? ☐ Yes ☐ No
Swelling of the ankles or leg cramps? ☐ Yes ☐ No
If YES, Please Explain:

Asthma ☐ Yes ☐ No Chronic or bloody cough ☐ Yes ☐ No Difficulty Breathing ☐ Yes ☐ No
Lung Disease ☐ Yes ☐ No TB ☐ Yes ☐ No Wheezing ☐ Yes ☐ No
If YES, Please Explain:

Bladder Disease, Infection, or Stones ☐ Yes ☐ No Blood Urine ☐ Yes ☐ No
Frequent or painful urination ☐ Yes ☐ No Kidney Disease ☐ Yes ☐ No
If YES, Please Explain:

Fractures ☐ Yes ☐ No Freq or Severe Headaches ☐ Yes ☐ No
Head Injuries/Loss of Consciousness ☐ Yes ☐ No
If YES, Please Explain:

Bi-polar Illness ☐ Yes ☐ No Convulsions/Seizures ☐ Yes ☐ No Dizzy Spells ☐ Yes ☐ No
Emotional Problems ☐ Yes ☐ No Fainting ☐ Yes ☐ No Insomnia ☐ Yes ☐ No
If YES, Please Explain:

Arthritis ☐ Yes ☐ No Back, Joint, or Bone Problems ☐ Yes ☐ No Skin Problems ☐ Yes ☐ No
If YES, Please Explain:

Abdominal Pain ☐ Yes ☐ No Constipation or Diarrhea ☐ Yes ☐ No Liver Disease ☐ Yes ☐ No
Stomach or Digestion Trouble ☐ Yes ☐ No
If YES , Please Explain:

Menstrual difficulties, hot flashes, bloating, headaches before or with period, or PMS?
Are your periods regular? ☐ Yes ☐ No Last period?

Do you use Tobacco? ☐ Yes ☐ No	How Much/How Often:	Do you use Alcohol? ☐ Yes ☐ No	How Much/How Often:

Anything else you think your doctor should know? ☐ Yes ☐ No If yes, please explain:

WEIGHT NO MORE – NOTICE OF PRIVACY PRACTICES

Patient Name:	Date of Birth:

Due to government regulations we are required to have you sign the Privacy Policy for this office. If you would like to read the entire policy, please request a copy from the front desk. Your privacy is strictly guarded and no information is released without your signed authorization.

We want you to know that we respect and protect the privacy of your personal information. As healthcare providers, we are governed by the Health Insurance Portability and Accountability Act (HIPAA) and the "Privacy Rule". As such, we need your consent for the use and disclosure of your personal healthcare information (PHI) in order to carry out your treatment.

It is our policy to properly determine the appropriate use of PHI in accordance with the government rules and regulations. As a part of this plan, we have implemented a compliance program that oversees the use of PHI. All employees, managers, nurses, and physicians continually undergo training on how to comply with government rules and regulations regarding HIPAA and the "Privacy Rule". We strive to achieve the highest standard of ethics and integrity in performing services for our patients. Only when it is deemed appropriate and necessary to carry out treatment, payment, or other healthcare operations will we provide other entities with your PHI (examples of such entities are hospitals, surgery centers, laboratories, and billing companies).

You have the right to revoke this consent except where we have already made disclosures based upon your prior consent. You may use our "Authorization for Release of Information Form" to revoke your consent or you may simply send us a letter.

I have read and understand the policy as outlined above. I understand my rights under the HIPPA regulations and those of this medical office. I authorize Weight No More to use and disclose my PHI for treatment, payment or other healthcare operations. I understand that if I do not sign this form Weight No More has the right to refuse to treat me.

Signature of Patient:	Date:

PATIENT CONSENT

I authorize Weight No More to release information pertaining to my treatment and care to the following:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

XXX

_____

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____

Physician's or Authorized Representative's Signature (Date)

Wayne Scheidemann MD - BMIXL LLC, DBA Weight No More

Print or Stamp Name of Physician

By: _____

Patient's Signature (Date)

By: _____

Print Patient's Name

A copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

WEIGHT NO MORE – WEIGHT LOSS AGREEMENT

PATIENT NAME: _____

Weight No More Policy

If you achieve a reasonable amount of weight loss after your first 3 months of treatment, we may be able to reduce the amount of medication you require.

If you have not achieved a reasonable amount of weight loss after the first 3 months, we will reassess your situation and discuss changes and additional approaches to help you reach your weight goal.

If, after another 3 months (6 months total), you have made good progress toward your goal, we will discuss whether or not you need to continue the medications.

If you have not made good progress, we may need to discontinue the medication component of your weight loss strategy. We will discuss lifestyle changes to help you reach your weight goal.

The medication provided to you is not to be shared, transferred, traded, or sold to other people. This is illegal and considered criminal activity.

Please keep the medication safely stored and out of the reach of children.

Date: _____ Signature: _____

WEIGHT NO MORE – MEDICATIONS BY MAIL

Patient Name:	Date of Birth:

I am a patient of Weight No More, have had my medical history reviewed, and have been personally examined by a medical provider at Weight No More.

I have received nutrition and exercise advice by Weight No More. The risks and benefits including side effects of the medication(s) have been provided to me as well as alternatives to treatment. All have been explained to my satisfaction.

I now request to receive my medication(s) by mail. I realize that it is very important and MY RESPONSIBILITY to keep the medical provider with Weight No More informed of any changes in my health or the medications which other medical providers prescribe for me. I will inform my Primary Medical Physician about the Weight No More medications I am taking.

I agree to provide my blood pressure and weight monthly. If I should develop high blood pressure or any heart problem, I will stop taking my Weight No More medication(s) and call the Weight No More provider for advice.

I agree to hold harmless Weight No More and its providers from any liability if I do not comply with the terms of this agreement to receive medication(s) by mail.

Signature of Patient:	Date:

WEIGHT NO MORE – PRESCRIPTION PICK UP

I, _____, herby authorize the individual(s) listed below to pick up my prescription(s) for me at Weight No More:

Name:	Relationship:
Name:	Relationship:

I understand that my agent/representative must provide a valid photo identification each time he/she picks up my prescription(s). This authorization will remain active until I revoke it by contacting the staff at Weight No More.

Patient Signature:	Date:

Only complete below if request has been revoked:

Revoked On:	By: