WEIGHT MANAGEMENT CONSULTATION FORM

Name : ____ Date : _______________________

Date of birth : _____________________ Age : _______________ ☐Male ☐Female ☐ Non-Binary

Address: ____

City: ______________________________State : _____________ Zip Code : __________________

Phone:________________________________ Email : _________________________________

Emergency Contact: _____________________________ Phone Number: ______________________

How did you hear about us?____

Are you referred by someone? If so, whom?____

Would you like to be added to our email list for news and exclusive offers? _______________________

MEDICAL HISTORY

Please mark any of the following conditions you may currently have

- ☐ High Blood Pressure
- ☐ Breastfeeding
- ☐ Bleeding Disorders
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Fillers/Botox
- ☐ Hepatitis
- ☐ Pregnancy
- ☐ Recent Gastric Surgery
- ☐ Birth Control
- ☐ Seizures
- ☐ Pancreatitis
- ☐ Alcohol Use Disorder
- ☐ Illicit Drug User
- ☐ Past addiction disorder
- ☐ Other _____________

Any other conditions? ____

If you ticked any boxes, please give further details ____

____

Do you have any allergies? ☐ Yes ☐ No

If so, please list all ____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones, and topical

____

____

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

HEIGHT: ____________

CURRENT WEIGHT: __________

DESIRED WEIGHT: __________

<u>By signing below, you agree to the following:</u>

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

____________________________ ____________________________

Patient Name (Printed) **Patient Signature**

____

Date

WEIGHT MANAGEMENT
PATIENT TREATMENT RECORD

Name : ______________________________ Date : ____________________

Date of birth : ________________ Age : ____________ ☐Male ☐Female ☐ Non-Binary

Address: ____

City: ________________________State : __________ Zip Code : ______________

Phone:_________________________ Email : ____________________________

NO	DATE	WEIGHT	DOSE	TREATMENT NOTES	PRICE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

WEIGHT MANAGEMENT
PHOTO AND VIDEO RELEASE FORM

I, ____________________________ hereby grant and authorize **RIOS HEALTH AND BEAUTY.** I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of **RIOS HEALTH AND BEAUTY** and will not be returned to me.

I hereby release and discharge **RIOS HEALTH AND BEAUTY.** from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

____________________________	____________________________	____________________________
Patient Name (Printed)	Patient (signature)	Date

WEIGHT MANAGEMENT CANCELATION POLICY

To ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a $50 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours before your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours' notice, a $50 cancellation fee will be charged.

Please note that if you arrive more than 20 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Patient Name (Printed)	Patient (signature)	Date