ALLURE Medical Weight Control & Wellness

Health History Questionnaire

I.D. Verified:__________ Exp:______

All questions in this questionnaire are strictly confidential and will become a part of your medical record.

Name: (Last, First, M.I.) ________________________________ Date of Birth:__________

Address: ________________________ City:____________________ Zip Code:__________

Telephone: ______________ Cell: ______________ Email address: ______________

How did you find out about our facility? ________________________________

DO YOU SUFFER WITH/FROM?

Please circle Yes or No

Anxiety	Yes/No	Chest Pain	Yes/No	Swelling of hands or feet	Yes/No
Depression	Yes/No	Headaches	Yes/No	Leg cramps	Yes/No
Suicidal/Homicidal Thoughts	Yes/No			Dizziness	Yes/No
Insomnia	Yes/No	Fatigue	Yes/No	Difficulty Breathing	Yes/No
Stress	Yes/No	Constipation	Yes/No	Diarrhea	Yes/No

PERSONAL HEALTH HISTORY

Surgeries:	Illness or Injuries:	Medications (currently taking):
Any problems with your heart or blood pressure? Yes/No	Allergies to any Medications?	Any other allergies?

FAMILY HEALTH HISTORY

Please circle Yes or No

Cancer	Yes/No	Heart Disease	Yes/No
Diabetes	Yes/No	Thyroid Disease	Yes/No
High Blood Pressure	Yes/No	Kidney Disease	Yes/No

HEALTH HABITS AND PERSONAL INFORMATION

Please circle Yes or No

Exercise: None/Mild/Regular	Do you drink Alcohol? Yes/No How much? How often?	Do you use tobacco? Yes/No How many cigarettes per day?
Do you have trouble losing weight?	How many times have you tried to lose weight?	Drugs (street or recreational): Yes/No What type?________
Have you ever taken medication to lose weight?		

Patient Consent: I have read and understand the above and do hereby agree to the treatment administered to me, including medication for weight control.

Signature: ________________________________ Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of David C. Stanford, M.D.'s Notice of Privacy Practices.

I further acknowledge that a copy of the current notice will be posted in the reception area, and that I and that I will be offered a copy of any amended notice of Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

____________________________ __________________
Signature Date

____________________________ __________________
Print Name Telephone #

____
Date of Birth

If not signed by the patient, please indicate relationship:

Check one:

_____ Parent or Guardian

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of the Patient: ____________________________________

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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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in 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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred *to* as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born 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 both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision (s) of this Agreement is declared void and/or unenforceable, such provision (s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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 I OF THIS CONTRACT.

By:______________________________
Physician's or duly Authorized Representative Signature (Date)

By:______________________________
Print or Stamp Name of Physician, Medical Group or Association Name

By:______________________________
Signature of Translator (if applicable) (Date)

____
Print Name of Translator

By:______________________________
Patient's Signature (Date)

____
Print Patient's Name

By:______________________________
Patient's Representative's Signature (if applicable) (Date)

____
Print Name and Relationship to Patient

ALLURE Medical Weight Control & Wellness

Refund Policy

Refunds will be honored for valid medical contradictions only. These contraindications must be documented in writing by your primary care physician or other medical specialist where you are currently under their care. This documentation must be presented to our office no later than 30 days from your last purchase of such medications or supplements. The discount will pertain to the last credit purchased in your records within 30 days. In this instance, the discounted price will be voided. The medication or injections will be charged at the regular price and will be deducted from the remaining amount to your refund.

No refund credit for prior patients that have not been on the program greater than or equal to one year from their last visit.

No refund credit will be issued if there is evidence of omission or falsification of health history that results in the termination of any portion of the program.

Please sign and date that you have read and understand the refund policy.

________________________________ Signature

____________________ Date

Thank you for your cooperation.

ALLURE Medical Weight Control & Wellness

EKG Protocol

Per our protocol here at ALLURE and the guidelines of the American Medical Association and World Health Organization, anyone over or equal to the age of 45 will need to have an EKG annually prior to starting or resuming Phentermine or Phendimetrazine. Anyone under 45 yrs old with history of chest pain, shortness of breath, palpitations, fluttering or arrhythmias will also need to have an EKG.

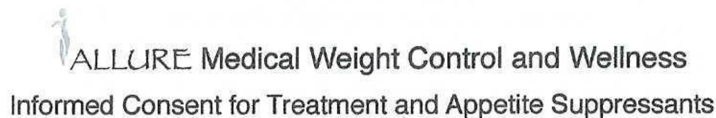
If you have had a normal EKG within the past 12 months, please provide our office with a copy, and we will be able to move forward with the prescription weight loss program.

The cost for the EKG is $20. This amount is due when the service is rendered and whether the EKG is normal or abnormal.

You will be advised regarding the results and recommendations upon completion of the study.

____ _______________

Signature Date



ALLURE Medical Weight Control and Wellness

Informed Consent for Treatment and Appetite Suppressants

Patient Name (Print):______________________________________ Date of Birth: ___________________________

Your success depends upon your commitment to fulfilling your obligations during treatment. You should be willing to:

1. Provide complete answers to questions about your health. List all prescription and over the counter medications.
2. Devote the time needed to complete and comply with the course of treatment as prescribed.
3. Attend the weekly office visits and follow your recommended caloric intakes and exercise regimen.
4. Obtain blood/diagnostic test which your M.D., N.P. or P.A. deem necessary during your treatment.
5. Advise the medical staff of ANY concerns, side effects, complaints, symptoms, or any questions regarding your health and your prescribed or over the counter medication.

Risks associated with being overweight:
Hypertension, Diabetes Mellitus, High Cholesterol, Asthma, Esophageal Reflux, Fatigue, Heart Attack, Stroke, Peripheral Vascular disease, Abnormal Cardiac Rhythms, Pulmonary Hypertension, Sleep Apnea, Arthritis and Polycystic Ovarian Syndrome

These risks/conditions may be reduced or eliminated with weight loss.

Common Side Effects of Phentermine and Phendimetrazine:
Fast,Irregular, pounding heartbeat (pulse), Insomnia, Excessive thirst, headaches, trouble breathing, dizziness, constipation, skin rash, unpleasant taste, drowsiness, Anxiety/Depression, Restlessness, Tremors, Impotence, Libido changes, Abdominal pain

Gallstones: Overweight people will develop Gallstones at a higher rate than Individuals at a normal weight. It is possible to have Gallstones and not know it. As your body weight and age increases, so does the risk of developing Gallstones. The risk is even higher for women taking Estrogen and smokers. Losing weight rapidly may increase the risk of developing Gallstones, increasing the size of potential stones and/or sludge within the Gallbladder. Symptoms include but are not limited to fever, nausea/vomiting and/or right upper quadrant abdominal pain. If you develop symptoms and know and or suspect that you may have gallstones, notify your Physician immediately. Gallbladder issues may require medications and surgical intervention and less commonly may be associated with more serious complications and death.

Pancreatitis: or inflammation of the Pancreas may be associated with Gallstones or sludge. As body weight and age increase, so does the chance of developing gallstones. These chances double for women, women using estrogen and smokers. Losing weight especially rapidly may increase the chance of gallstones or sludge and/or increase the size of existing stones within the gallbladder. Should symptoms develop (fever, nausea and right upper quadrant pain) or if you suspect that you have gallstones, let your medical provider know immediately. Gallbladder problems may require medications and or surgery to remove the gallbladder, and less commonly, may be associated with more serious complications or even death.

Pregnancy: I understand that Phentermine or Phendimetrazine should not be taken during **pregnancy** or **breastfeeding**, due to the chance of damage to the fetus/infant. This has been explained to me fully, and I am aware of the risk involved. **To the best of my knowledge, I am not pregnant at this time, nor do I plan to get pregnant during the time I am taking Phentermine/Phendimetrazine medication.** I am aware of the precautions that should be taken to avoid pregnancy while I am on medication, If I become pregnant, I will advise both the clinic and my OB/GYN immediately.
___________**Initial**

Your Rights and Responsibility:
You may leave treatment at any time. You have a responsibility to notify the physician of any changes in your medical history, and to find another physician who is able to assume medical care for you after you leave treatment.

No Guarantees: I understand that much of the success of the program will depend on my efforts and the advice the medical staff will provide for me. There are no guarantees that the program will be successful. I also understand that I will have to continue watching my weight and maintaining my weight loss to be successful.

Appetite Suppressants

Phentermine and **Phendimetrazine** are approved by the Food and Drug Administration (FDA) as an appetite suppressant for the short term management of obesity. Medication will be prescribed for 12 weeks followed by a re-evaluation. The physician will determine the purpose of restarting a weight loss program.

Long Term Use: Additionally, an anorectic medication may be used for individuals that have shown previous benefit and not had adverse reactions (beneficial risk-to-benefit ratio) for the purpose of restarting a weight loss program, to lose weight that had been recently gained following a therapeutic loss of weight, or to maintain weight loss on a chronic basis even if the above criteria are no longer met.

Dispensing and Furnishing: Appetite suppressant or other weight loss related medication will be prescribed and dispensed within Dr.Stanford's office. I understand that I have a choice to obtain a prescription for appetite suppressant to use at ant pharmacy of my choice.

It is your responsibility to follow dosing instructions carefully and to report promptly any medical problem(s) that may be related to the medication or your weight control program. In general, medications will **NOT** be prescribed or refilled without an office visit. We reserve the right to refuse treatment for weight loss. Abuse of this policy can result in dismissal from the clinic.

My continuing to receive appetite suppressants will be dependent on my progress in weight reduction and weight maintenance

Drug Testing ... If you are drug tested as part of your employment or for another purpose, you may test positive for methamphetamine. If needed, you may be given a doctor's note to state you are taking a prescribed medication to aid weight loss

Alternatives: We offer Natural Appetite Suppressant for patients that do not qualify for Phentermine or Phendimetrazine due to pre-existing medical conditions.

Participant Signature:____ **Date:**______________

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have and have answered any questions posed by the patient. I believe the patient/relative/guardian fully understands what I have explained and answered.

Physician/Provider Signature:____ **Date:**______________