

**NEW PATIENT/RESTART PATIENT INFORMATION FORMS**

**Name: Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.:\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? (Please check all that apply.)**

|  |  |
| --- | --- |
| \_\_\_\_\_\_ Radio | \_\_\_\_\_\_ Mail-Out |
| \_\_\_\_\_\_ Internet | \_\_\_\_\_\_ Sign |
| \_\_\_\_\_\_ Television | \_\_\_\_\_\_ Newspaper |
| \_\_\_\_\_\_ Word of Mouth/ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**EMERGENCY CONTACTS**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL POLICY**

This is to inform you of our billing requirements and 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, Discover, American Express, and cash. I have read and understood all of the above information and have agreed to these statements.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**HIPAA PRIVACY NOTICE**

I have received/reviewed a copy of the HIPAA privacy notice (Located on the last page of the “Roadmap to Success” booklet).

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**LABS REQUIRED**

Patients must have their labs drawn at Bee Healthy or must have provided a copy prior to receiving their second RX. If they have had labs done recently, they must submit a copy. The labs cannot be older than 90 days, and must contain all required tests. Labs can be drawn at the clinic on the refill date for an additional fee. RX can be dispensed if labs are drawn in the clinic on that day. I have read and understood all of the above information and have agreed to these statements.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS**

I.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient/guardian name), understand and acknowledge that treatment by Bee Healthy Medical Weight Loss, LLC, Dr. Allen Hicks, MD, and their designated assistants is limited solely to assistance with weight reduction efforts. This treatment does NOT provide a substitute or replacement for any regular physician. Bee Healthy Medical Weight Loss, LLC, and Dr. Allen Hicks, MD, do not treat acute or chronic medical problems, and I agree to see my regular physician for these problems.

II.

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient/guardian name), authorize Dr. Allen Hicks, MD and whomever he designates as his assistants to assist me in my weight reduction efforts. I understand that my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher/lower doses than the dose indicated on the appetite suppressant labeling. I understand that my program may consist of a balanced deficit diet, a regular exercise program, and instructions in behavior modifications techniques.

2. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight reduction process, any significant medical problems that I think may be related to my weight control program as soon as possible.

3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and maintenance.

III.

1. RISKS OF PROPOSED TREATMENT:

I understand this authorization is given with the knowledge that the use of the appetite suppressant for more than twelve weeks and in higher doses than the dose indicated on the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious risks include: primary pulmonary hypertension and valvular heart disease. These and other possible risks could be serious, or fatal.

2. NO GUARANTEE:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that after I complete my weight loss, I will have to continue watching my weight and keep practicing healthy lifestyle choices, if I am to be successful.

3. PATIENT’S CONSENT:

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, or any questions I have concerning them have not been answered to my complete satisfaction, I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I also understand that participation in this program is strictly voluntary and it is my choice to participate or not. I understand that I may discontinue this treatment at any time at my discretion.

4. WARNING:

If you have any questions as to the risks or hazards of the proposed treatment, or any questions whatsoever regarding the proposed treatment or other possible treatments, ask your doctor now before signing the consent signature form.

I have read and fully understand this consent form.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**PATIENT MEDICAL HISTORY**

**Present Health Status:**

1. Are you in good health at the present time, to the best of your knowledge? YES NO

if “NO,” explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you under a doctor’s care at the present time? YES NO

If “YES,” explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you taking any medications at the present time? YES NO

List all prescribed medications and over the counter medications.

**Please check box to note if medication is prescribed (RX) or Over the Counter (OTC).**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of the Medication | RX | OTC | Dosage | Schedule |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

4. Any allergies to sulfa/sulfur type medications or *any other medications*? YES NO

If “YES,” please list below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following?:**

|  |  |  |
| --- | --- | --- |
| 5. History of High Blood Pressure? | YES | NO |
| 6. History of Diabetes? | YES | NO |
| Type I \_\_\_\_\_\_\_ Type II \_\_\_\_\_\_\_ At what age? \_\_\_\_\_\_\_ |  |  |
| 7. History of Heart Attack or chest pain or other heart condition? | YES | NO |
| If “YES,” explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 8. History of swelling feet? | YES | NO |
| 9. History of frequent headaches or migraines? | YES | NO |
| 10. History of constipation (Difficulty in bowel movements)? | YES | NO |
| 11. History of Glaucoma? | YES | NO |
| 12. History of Sleep Apnea? | YES | NO |
| Do you use a C-PAP? | YES | NO |
| 13. Any surgery/surgeries? | YES | NO |
| Specify with date:  1.  2.  3. |  |  |
| 14. Do you have any other medical problems or concerns? | YES | NO |
| If “YES,” explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Medical History Continued (Check all that apply)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Gallbladder disease |  | Heart valve disorder |  | Drug abuse |  | Kidney disorder |
|  | Liver disease |  | Depression/anxiety |  | Heart disease |  | Anemia |
|  | Ulcers |  | Psychiatric illness |  | Lung disease |  | Bleeding disorder |
|  | Eating disorder |  | Alcohol abuse |  | Arthritis |  | Thyroid disorder |
|  | Gout |  | Cancer |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Family History (Please complete this section in its entirety)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Age | General Health | Disease(s) | Overweight | Cause of Death |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Brother(s) |  |  |  |  |  |
| Sister(s) |  |  |  |  |  |

Has any blood relative ever had any of the following?:

High Blood Pressure: YES NO Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease: YES NO Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart attack/Stents/Bypass/Stroke: YES NO Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did they have their heart problems/stroke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This is a complete and full disclosure and summary of my medical history.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**LIFESTYLE EVALUATION**

1. Do you drink coffee, soda, or tea? YES NO How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you wake up hungry during the night? YES NO How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.Previous diets and/or weight loss medications you have tried: list description (or name) and your results:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Do you drink alcohol? YES NO

Daily? YES NO

Weekly? YES NO

Occasionally? YES NO

5. Smoking habits (check one):

|  |  |
| --- | --- |
|  | You have never smoked cigarettes, cigars, or a pipe. |
|  | You quit smoking \_\_\_\_\_\_\_ years/months/days (circle one) ago and have not smoked since. |
|  | You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke. |
|  | You smoke \_\_\_\_\_\_\_ cigarettes per day. |

**CONSENT TO TREATMENT**

**(WOMEN ONLY)**

I understand that Phentermine and other anorectic medications should NOT be taken during pregnancy, due to the chance of damage to the fetus. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both the clinic AND my OB/GYN immediately.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Name Date**

**DISCLOSURE AND CONSENT FORM**

TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States: NOTICE: Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.

I voluntarily request that Dr. Allen Hicks, MD, and other affiliated health care personnel as he may deem necessary, treat my condition (or the condition of the person for whom I am responsible) as described below.

I understand that some or all of, the following integrative and alternative treatments are planned for me (or the person for whom I am responsible). I voluntarily consent and authorize the following: Administration of homeopathic remedies, herbal and nutritional therapies, off label use of pharmaceuticals, injectable vitamins and Amino Acids, B12 with or without Lipotropic, Choline, Methionine, Inositol.

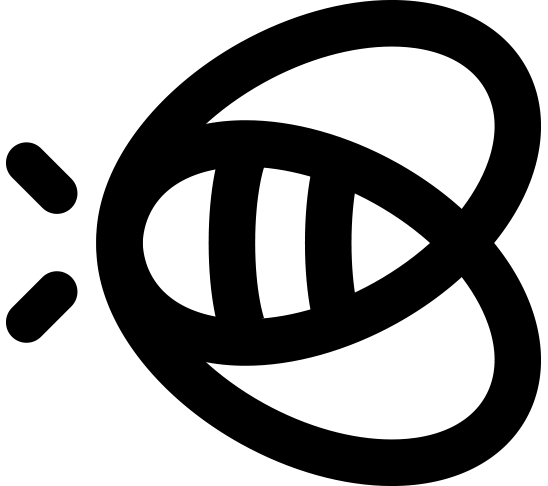
I understand that no warranty or guarantee has been made regarding results of treatment. I realize that there may be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox reactions) and undesirable interactions between various treatments, both conventional and alternative.

I have been given an opportunity to ask questions about the treatment of this health condition using conventional, integrative, and alternative methods. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment; I believe that I have sufficient information to sign this informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), that the blank spaces have been filled in, and that I understand its contents. I also certify that Dr. Allen Hicks, MD, and other affiliated health care personnel have provided this Disclosure and Consent Form to me, fully explained the diagnostic and treatment options available, and have made no guarantees to me as to the success of this treatment. I acknowledge that Dr. Allen Hicks, MD, and other affiliated health care personnel have informed me that they functions only as educators and consultants not as the primary care physician for any patient. I have assured him that I have a primary physician and do not/will not rely on Dr. Allen Hicks, MD, and other affiliated health care personnel for that role.

**SIGNATURE OF THE PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON REQUIRED BELOW:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Patient’s/Guardian’s Signature Print Name Date**



**CLINIC USE ONLY:**

**PHYSICIAN DECLARATION**

I have explained the contents of this document to the patient and have answered all the patient’s related questions and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of appetite suppressants, as well as the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician/NP/PA Signature Date**