About Face

HCG Initial Visit

(Patient to complete only first three lines of this page.)

Name:_____ Date of Birth_____ Allergies _____

Address:_____

Date: _____

CC:

Subjective: Here to start the HCG program:

Diets tried previously:_____ Goal weight: _____

Current exercise program:_____

Amount of H20 intake daily:_____

PMH/Meds:_____

Recheck Fxs, including pertinent Family History, see flow chart.

Objective: See HCG flow sheet for V/S, HT, WT, and Measurements

_____YO M,F, NAD

Chest: _____ CTA CV RRR, No Murmur Ext: _____ No Edema

A: Overweight/Obese/Morbidly Obese BMI:_____

P: Start HCG program – Counseled on global weight plan. All HCG information discussed in detail. Book and information given to client to read. Prescribed HCG, counseled on usage/VLC Diet.

About Face Weight Management Date: ___/___/___

Name:_____ Date of birth__/__/__ Allergies:_____

We will be doing all promotions via email. If you would like to participate, please list your email address so we can add it in our system. Email Address: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work/Other Phone:_____

Occupation:_____ Referred by:_____

Emergency Contact Name: _____ Number: _____ Relationship:_____

May we communicate with them regarding appointments, RX's, and lab results? Yes ☐ No ☐

Preferred Number that we contact you: ☐ Cell ☐ Home ☐ Work/Other

May we leave a message: Yes ☐ No ☐

We have offices two locations, please check the office that you may visit.

Bristol___ Abingdon___

Health History

Please circle any that apply:

Migraine headaches	Self	Family History	Lung Disease	Self	Family History
Cancer	Self	Family History	Kidney Disease	Self	Family History
Diabetes	Self	Family History	Stomach Disease	Self	Family History
Heart disease	Self	Family History	Bowel Disease	Self	Family History
Arthritis	Self	Family History	Alcoholism	Self	Family History
Liver Disease	Self	Family History	Gout	Self	Family History
Psychiatric illness	Self	Family History	Hepatitis	Self	Family History
Auto immune disease	Self	Family History	Anemia	Self	Family History
Thyroid disorder	Self	Family History	Colitis	Self	Family History
High blood pressure	Self	Family History	Epilepsy	Self	Family History
Stroke, seizures	Self	Family History			
Parkinson's disease	Self	Family History			

Primary care physician:_____ Are you pregnant or nursing: Yes or No

Have you had any surgery within the past 2 years: Yes or No Reason:_____

Please list all medications that you are currently taking, including hormones:

Please note—if you are being treated with either Methadone or Suboxone at a clinic, it is illegal for you to seek Phentermine while you are being treated.

Name:_____ Dose (mg)_____ Times a day___

Name:_____ Dose (mg)_____ Times a day___

Name:_____ Dose (mg)_____ Times a day___

Name:_____ Dose (mg)_____ Times a day___

Name:_____ Dose (mg)_____ Times a day___

These questions refer to your current status:

Alcohol consumption: Drinks/week____ Do you smoke? Yes or No Packs per day____

Coffee: Cups/day Diet drinks or other drinks with Aspartame/day____ Water, 8oz/day

Are you currently taking any vitamins, minerals or herbs on a regular basis? If so, please list:

_____

What are your most important expectations as a patient:_____

_____

_____

Do you crave sweets? Yes ☐ No ☐

Do you eat a lot of potatoes, bread, etc? Yes ☐ No ☐

Do you have occasional irregularity? Yes ☐ No ☐

Do you need an "extra boost" to your metabolism? Yes ☐ No ☐

About Face Weight Management

Injection Waiver and Responsibility

Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____

Waiver Request Date: _____

By signing this document the facility administrator and/or Doctor certifies that the following documents are in place. Prescription for treatment in the patient's file, physician orders for treatment are in the patient office files, and training has been provided by the staff with supporting documentation on file.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Doctor/NP

Nick Patel, MD and Sue Cressel, NP

Signature of MD/NP:_____

About Face

Notice of Privacy Practices

Users and disclosures of protected health information:

Your protected health information may be used and disclosed by your provider to an office that is involved in your care and treatment for the purposes of providing health care services to you. The following information is an example of the types of uses and disclosures of your protected health information that your provider is permitted to make. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made to our provider.

If you have any questions about this Notice, please contact our Privacy Officer who is: Sue Cressel, Owner

Treatment:

Our provider will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This may include communication with other health care providers regarding your treatment, coordinating and managing your health with others. For example, we would disclose your protected health information to other providers who may be treating you. Your protected health information may be provided to other healthy providers to whom you have been referred to so that we can ensure that the provider can diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another provider or health care providers (e.g… specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment may use or disclose your protected health information, as necessary, to provide information about treatment alternatives or health-related benefits and services that may be of interest to you. We may send you information about our product or services we believe may be beneficial to you. You may contact this office to request that these materials not be sent to you or anyone else.

Uses and Disclosures of protected health information based on upon your written authorization or opportunity to object:

Other use and disclosures of your protected healthy information will be made only with written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time in writing, except to the extent that your provider's practice has taken an action in reliance on the use or disclosures indicated in the authorization.

Other permitted and required use and disclosures may be made with your authorization or opportunity to object. We may use and disclose your personal healthy information in the following instances: You may have the opportunity to agree or object to the use and disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Acknowledgement of Receipt of Privacy Practices:

_____ _____

Patient Signature Date

_____ _____

Authorized Provider Signature Date

About Face Weight Management

HIPPA Form

Acknowledgement: Notice of Privacy Practices

(Please Print)

Date: _____ Email: _____

Last Name: _____ First Name: _____

Phone: _____ Date of Birth: _____

Address: _____

Drug Allergies:_____

Chronic Conditions:_____

I acknowledge that I have received the Notice of Privacy practices:

Signature:_____

Prohibition on re-disclosure

This information has been disclosed to you from records whose confidential is protected by state law and/or may be protected by Federal confidentiality rules. State law prohibits you from making any further disclosure of it without consent of person to whom it pertains, or as otherwise permitted by state law.