

About Face
615 Volunteer Parkway
Bristol, TN 37620
(423) 989.3223

Notice to All Weight Loss Clients:

About Face does not prescribe phentermine to patients under the care of a physician prescribing anti-abuse medications for the treatment of opioid addiction. These medications commonly consist of methadone and suboxone. If you are seeking phentermine for weight loss while taking methadone or suboxone, you should contact your prescribing physician and ask that they write this prescription. There are no exceptions to this policy. We apologize for any inconvenience.

Only after a patient has completed a suboxone or methadone treatment, and it has been greater than 90 days since completion of that treatment, will we consider offering a phentermine-based weight loss plan.

About Face is required by law to participate in the Controlled Substance Monitoring Database ("CSMD") prior to prescribing phentermine. As required by this program, we regularly monitor existing and potential patients prescribed medications prior to writing any prescription. Likewise, if we prescribe phentermine, we input this information into the database.

Prior to completing your weight loss application, please answer the following questions by circling the correct answer:

1) Are you in a treatment program for opioid addiction?

Yes No

2) Have you been prescribed an opioid-addiction medication such as suboxone or methadone?

Yes No

3) Have you been prescribed phentermine by another medical professional in the last 30 days?

Yes No

If you answered yes to any of the above questions, you are not a candidate for the phentermine weight loss medication.

Signature: _____

Date: _____

Allergies: _____

About Face Client Weight Loss Notes – Initial Visit *(Complete gray areas only on this page)*

Name: _____	DOB _____
Address: _____	
Date: _____	
Male/Female (Circle One)	Goal Weight: _____

Here to start global weight loss program. Has/Has not taken phentermine before?

Currently no CP, shortness of breath, edema. No other problems.

See Patient History Sheet for PMH, Meds, Risk Factors, SH, FH; ROS o/w neg.

Objective: Vitals – See Flow Sheet

Gen. Pleasant, WD/WN, NAD

Chest: CTA, no crackles/wheezes

Heart: RRR, no murmur

Extremities: No edema

Assessment: Overweight/Obese Morbidly Obese Healthy Overall

Other Health Problems and Status: _____

Plan: Counseled on global weight plan. Prescribe phentermine and advised medication is only a portion of a whole weight loss plan. Counseled on initiation and use of phentermine and possible SE's to look for. Stop meds and call here or other medical center if problems. Counseled on daily water intake of at least 60-80 oz/day. Eat small amounts through day and not starving oneself to keep up metabolism, proper diet, and other behavior modifications. Balanced healthy low carb, low fat discussed.

Exercise Plan: At least 4 times weekly for at least 15-30 minutes, getting heart rate to a target range.

Continually build on this. Patient plans to embark on a plan of:

Other treatments planned: _____

Follow plan discussed: Phentermine 37.5 mg take ½ tab PO qd. X 1 week, then increase as RX and/or needed. Risk/Benefits discussed, i.e., elevated blood pressure, increased heart rate, 1200/2000 calorie diet. Follow up in 30 days.

Additional Notes:

Provider Signature: _____

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 two office locations; please check the office that you may visit. Bristol ___ Abingdon ___

Health History - Please circle any that apply:

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

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:

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 _____

IMPORTANT!!!!

If you are being treated with Methadone or Suboxone at a clinic, it is illegal for you to seek Phentermine while you are being treated.

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

Phentermine Consent Form

Please initial in front of each paragraph on the line provided. Your initials represent that you have read and understand the information provided to you about Phentermine. Please address any questions regarding this form to the clinic staff, practitioner or doctor.

____Phentermine is an appetite suppressant that has been taken safely by millions of people, but as with any medication, there is the possibility of side effects and adverse reactions. Dry mouth, nervousness, and difficulty sleeping are side effects and are experienced within the first few days of taking phentermine. It takes your body approximately 4 to 7 days to adjust to the medication. Usually any nervousness or sleeplessness will resolve within the first week. Some clients find it helpful to take a dose of liquid Benadryl at bedtime for a few days to assist in falling asleep while your body adjusts to the medication.

____Other less common side effects are: mental disturbance, palpitations (fluttering of the heart rate), abnormal heart rhythm, increase in blood pressure, shortness of breath, swelling in the feet and ankles, exercise intolerance, dizziness, upset stomach, constipation, itching, skin rash, sexual problems and difficulty in passing urine. Phentermine comes with the RARE potential to cause pulmonary hypertension and heart valve disease. This is increased when taking an antidepressant while taking phentermine.

____In the case of a serious side effect, stop taking Phentermine and seek immediate medical supervision at your local ER. All patients on Phentermine are required to be evaluated by the physician every 60 days or every other month. While taking Phentermine, AVOID taking the following medications: (Sudafed/Pseudoephedrine, Tylenol Sinus, Claritin D, Zyrtec D and Allegra D are a few examples), stimulant medications, high doses of caffeine, other weight loss medications, ephedra, MAO inhibitors, and the use of alcohol. Please consult the clinic staff before taking any new medication while using Phentermine.

____Persons with the following medical conditions are NOT to take Phentermine: those with uncontrolled high blood pressure, heart disease, history of heart attacks or angina, arteriosclerosis (clogging of the arteries), symptomatic severe heart murmurs, history of stroke, liver or kidney failure, overactive thyroid, glaucoma, uncontrolled anxiety, depression, and those with a history of drug dependency (or addiction prone personality). Phentermine is NOT to be taken while pregnant or breast feeding. The use of Phentermine must be discontinued at least two weeks prior to any surgery where general anesthesia will be used.

____When first starting on Phentermine, take your dose as soon after awakening as possible to lessen the possibility of it disturbing your sleep. After the first week (or as soon as you are sleeping normally), you may change the time of day you take your dose to meet your personal needs. Those that experience difficulty controlling their appetite in the evening hours may find it to their benefit to take their dose between 10 am and 2 pm as long as it does not interfere with your sleep.

____Patients are required to lose 4 pounds per month in order to continue the Phentermine regimen. Patients who consistently fail to lose, or those who gain weight will be taken off the medication and counseled regarding other treatment options.

Your signature represents that all information provided by you is truthful. Any other and all medical conditions and/or treatments you withhold from About Face will not become About Face's responsibility.

Patient Signature

Date

Medical Provider

Date

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 health care 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