Ana Morales, M.D. **Jan Knight Bateman, M.D.**

PLEASE READ ALL PAGES AND SIGN

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the medicines and length of medicine usage may be used in an "off label" manner. This means the doctor may be using the medicines in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, lifestyle patterns, medication or drug usage (including any weight loss meds, DEA controlled meds, stimulant type medications, and any or all habit forming drugs) to help us best help you.
2. Devote the time and effort necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal physician if necessary.
4. Make and keep follow-up appointments and allow laboratory tests as needed.
5. Advise the clinic staff and Dr. of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a personal physician before beginning this program.

Possible Side Effects

1. **Reduced weight.** By reducing your caloric intake may give a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, or diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above, dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure.
2. **Reduced potassium levels or other electrolyte abnormalities.** These can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We may need to follow your levels with occasional blood testing.
3. **Gallstones.** Overweight people are at risk for having or developing gallstones. These can develop in overweight patients. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. Notify your doctor or us if you develop symptoms of Gallstones including, abdominal pain, fever, nausea and vomiting. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or surgery to remove the gall bladder.
4. **Pancreatitis.** Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight

loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs. You should take precautions to avoid becoming pregnant during weight loss.

6. **Sudden death.** Patients with obesity especially those with associated high blood pressure, diabetes, heart disease have a higher risk of sudden death and development of a serious potentially fatal disease Primary Pulmonary Hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.

7. **Risk of weight regain.** Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued.

Consent for photography

I consent for "before" and "after" pictures to be taken.

Your Rights and Confidentiality

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

Patient Name	Patient Signature	Date

(HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Information that We May Make Without Written Authorization: Treatment, Payment, Healthcare operations, required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody.

Uses and Disclosures of Information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. If you object, please notify the Privacy Contact identified at the end of this document.

Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Notification: Unless you object, we may use or disclose protected health information to notify a family member or

other person responsible for your care of your location and condition.
Your Right Concerning Your Protected Health Information: You have the following rights concerning your

protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may files a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.
Entities to Whom This Notice Applies: This notice applies to the Center for Healthy Weight, their associated clinics, the physicians, employee, and volunteers who work there.
Privacy Officer Contact: If you have any questions about this Notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Privacy Officer, Ana Morales, address 3203 E Broadway Pearland, Texas 77581 832-619-1373.
I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

Patient Name	Patient signature	Date

Center for Healthy Weight

HEALTH HISTORY QUESTIONNAIRE
Please print all information clearly.

Date: _____

Full Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Occupation/Place of Employment_____ SS#_____

Spouse's name_____ Primary Care Doctor_____

E-mail:_____ Age_____ Height_____ Sex_____

How did you hear about us?_____

When were your last labs drawn? _____ When was your last EKG? _____

Any allergies to medications? _____

Please list all medications (prescribed or over-the-counter), supplements, and/or vitamins you are currently taking:

_____

_____

_____

_____

DO YOU NOW OR HAVE YOU BEEN EVER TREATED FOR ANY OF THE FOLLOWING (PLEASE CIRCLE YES OR NO):

High Blood Pressure? Yes or No	Diabetes? Yes or No	Heart Disease? Yes or No
Thyroid Disorder? Yes or No	High Cholesterol? Yes or No	Hormones/Birth Control? Yes or No
Lung Disease? Yes or No e.g. Asthma	Depression? Yes or No	Sleep Disorder? Yes or No
Eating Disorder? Yes or No	Alcohol/Substance Abuse? Yes or No	Glaucoma? Yes or No

Date: _____ Full Name: _____

Please list any other serious illnesses you have had.

_____

_____

_____

Please list any major surgeries or injuries you have had.

_____

_____

_____

Do you smoke? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often? _____

FAMILY HISTORY (MOTHER/FATHER/SIBLINGS)

HEART DISEASE_____
STROKE_____
CANCER_____
DIABETES_____
HIGH CHOLESTEROL_____
OBESITY_____

NUTRITION

Present Weight: _____ Height : _____ Desired(Goal) Weight: _____

In what time frame would you like to be at your desired weight? _____

Weight at 20 years of age:_____ Weight one year ago:_____

What has been your highest weight and when? _____

What is the main reason for your desire to lose weight? _____

_____

Date: _____ Full Name: _____

Previous diets you have followed (include date and result):

_____

_____

_____

Any previous prescription weight loss medicine?

_____

_____

Do you exercise regularly? _____ How often? _____ Any problems with exercise? _____

Do you eat nutritious foods? _____

Do you eat excessively? _____ Do you count calories? _____

Do you have any food allergies/restrictions?

_____

_____

INITIAL EXAM (Check indicates normal) Waist circ. _____ Neck circ. _____ Hip circ _____

Weight _____ BMI _____ B/P _____ Pulse _____

Skin _____ Thyroid _____ Cardiac _____

Lungs _____ Leg Edema _____ Abdomen _____ Other Findings :

_____

_____

_____

_____

EKG _____

7. Is your spouse, fiancé or partner overweight? Yes No

8. By how much is he or she overweight? _____
   Does he or she encourage your weight loss plan? Yes No

9. How often do you eat out? _____

10. What restaurants do you frequent? _____

11. How often do you eat "fast foods"? _____

12. Who plans meals? _____ Cooks? _____ Shops? _____

13. Do you use a shopping list? Yes No

14. What time of day and on what day do you usually shop for groceries? _____

15. Food allergies: _____

16. Food dislikes: _____

17. Food(s) you crave: _____

18. Any specific time of the day or month do you crave food? _____

19. Do you drink coffee or tea? Yes No How much daily? _____

20. Do you drink cola drinks? Yes No How much daily? _____

21. Do you drink alcohol? Yes No

    What? _____ How much daily? _____ Weekly? _____

22. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

23. Do you awaken hungry during the night? Yes No

    What do you do? _____

24. What are your worst food habits? _____

25. Snack Habits.

    What? _____ How much? _____ When? _____

26. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

27. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

Jan Knight Bateman,M.D. **Ana Morales,M.D.**

MISSED APPOINTMENT POLICY

In an effort to better serve our patients, we ask that you give a minimum of 24 hours notice if you are unable to keep your appointment. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you, and your health care is important to us.

If you do not cancel your appointment with at least 24 hour advance notice or you fail to keep your appointment, you will receive a charge of $25.00.

An excessive amount of missed appointments could result in being discharged from our practice.

LATE POLICY

If you are late for your appointment, the receptionist will do the following:

Check with the provider or staff and see if you can be seen without delaying other scheduled appointments.

- Reschedule for another day.
- Reschedule same day for a different time, if available.

CELL PHONES AND PAGERS

To ensure that you have uninterrupted, quality time with your health care provider, we ask that you turn off your cell phone or your pager when you enter the examination room.

Thank you,

Signature_____ **Date**_____

CENTER FOR HEALTHY WEIGHT
Ana L. Morales, M.D.
Jan Knight Bateman, M.D.
3203 E. Broadway, Pearland, Texas 77581
T. 832-619-1373 F. 832-619-1378

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Please list any person (family, friends, other doctors, etc.) with whom **Center for Healthy Weight** may release your health and billing information:

Name:_____ Phone: _____

Name:_____ Phone: _____

Name:_____ Phone: _____

Name:_____ Phone: _____

Please note: In emergency situations we may share information with other who are not specifically listed on this form.

What is the best phone number for us to contact you? _____

What is this number? ☐ Home ☐ Cell ☐ Work ☐ Other _____

Is it ok to leave a detailed message on this number (that may include diagnosis and medical information)?
☐ Yes ☐ No

I understand I have the right to revoke/change this authorization in writing, at any time by sending a written notification to the following person at the practice. Otherwise, this authorization will be in force permanently.

Ana Morales, M.D. – Privacy Officer
3203 E. Broadway
Pearland, Texas 77581

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective is this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer the right to contest a claim under the policy or the policy itself.

I understand that information used of disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient (Parent if Minor) *Date*

_____
Printed Name of Patient (Parent if Minor)