Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Email Address: _____

Address: _____ City: _____

Sate: _____ Zip: _____

Home phone: _____ Cellular: _____ Work: _____

How did you hear about us: _____

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY

ID photo taken
VN:

Office Policy (Please initial each point acknowledging you understand that:

_____ If you miss your appointment, you may be subject to a $25 fee unless you call 24 hours in advance.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____Phentermine and Vyvanse are considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals. I understand that practice is not responsible for lost script.

_____I understand that treatments used might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department. I acknowledge that Dr Motamedy is not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed.

_____I understand that there are no refunds on shot packages purchased, services or products rendered. We cannot accept back used medications/ products once they have been dispensed per state regulation.

_____I understand that having an appointment with us does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with River Oaks/ Bellaire Beauty and Weight loss Center in regards to weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

I have read, understand, and agree to all the above statements.

Print Name: _____ Patient Signature ---------- Date----------

Confidential Communication Directive

In general the HIPAA Privacy Rule gives individuals the right to request a restriction on users and disclosure of their protected health information (PHI). The individual is also provided the right too request confidential communications or that a communication of PHI is made by alternative means.

PLEASE READ THE FOLLOWING CAREFULLY:

I authorize the following person(s) to call or pick up reports or medication in my absence unless otherwise directed. This includes phone and written communications and at work. Please initial by all that apply and specify names(s) of persons authorized to handle your protected information.

_____ Spouse _____

_____ Children _____

_____ Parents _____

_____ Siblings _____

_____ Grandparents _____

_____ Friends _____

_____ Other _____

PHONE COMMUNICATIONS—(Initial all that apply)

Home (____) _____ Work (____) _____

_____ Leave detailed message on voice mail _____ Leave detailed message on voice mail

_____ Leave call back number only _____ Leave call back number only

_____ Discuss my information with me only _____ Discuss my information with me only

_____ _____

Patient Signature Print Name

Date _____

Acknowledgement of Review of Notice of Privacy Practices

I HAVE REVIEWED OR BEEN OFFERED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

_____ _____

Signature of Patient/Personal Representative Print Name

_____ _____

Signature of Patient/Personal Representative Date

Weight Management History

Patient Name:_____ DOB:_____ Date:_____

PERSONAL HISTORY ILLNESS:
Do you have or have you had any of these in the past year:

Pneumonia	☐No	☐Yes
Rheumatic Fever or Heart Disease	☐No	☐Yes
Arthritis or Rheumatism	☐No	☐Yes
Gonorrhea or Syphilis	☐No	☐Yes
Anemia	☐No	☐Yes
Jaundice	☐No	☐Yes
Epilepsy/Convulsions	☐No	☐Yes
Tuberculosis	☐No	☐Yes
Diabetes	☐No	☐Yes
Cancer	☐No	☐Yes
High Blood Pressure	☐No	☐Yes
Liver Disease	☐No	☐Yes
Thyroid Disease	☐No	☐Yes
Anxiety Disorder	☐No	☐Yes
Glaucoma	☐No	☐Yes

ALLERGIES:

_____

_____

_____

HISTORY OF ALCOHOL OR DRUG ABUSE ☐No ☐Yes

WEIGHT:
Now:_____
One year ago:_____
Maximum:_____
When:_____

BLOOD TRANSFUSIONS: ☐No ☐Yes

SURGERY:

_____

_____

_____

_____

_____

_____

_____

_____

HEART AND LUNGS:

Chronic Cough	☐No	☐Yes
Coughing Up Blood	☐No	☐Yes
Shortness of Breath	☐No	☐Yes
Night Sweats	☐No	☐Yes
Chest Pain or Pressure	☐No	☐Yes
Palpitations or Fluttering	☐No	☐Yes
Swollen Ankles	☐No	☐Yes
Pacemaker	☐No	☐Yes

MENSTRUATION:
(Women)
When was your last period:

_____

Method of Contraception:

_____

GENERAL:

Unusual Fatigue	☐No	☐Yes
Unusual Weakness	☐No	☐Yes
Skin Trouble	☐No	☐Yes
Cold Intolerance	☐No	☐Yes

HABITS:
Coffee _____ cups per day.

Smoking:
Cigarettes _____ packs per day.

Alcoholic Beverages:
Present:
☐Light ☐Moderate ☐Heavy

Regular Exercise ☐No ☐Yes

MEDICATIONS:
Please list all medications:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____

Check off any of the dietary problem areas listed below that apply to you:

- ☐ Meal Skipping
- ☐ Carbohydrate craving
- ☐ Large portion size
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Eating foods too high in fat.
- ☐ Eating too many meals out in restaurants.
- ☐ Eating for reasons other than hunger.
- ☐ Eating before going to bed.

Do you ever binge on food: ☐No ☐Yes
Have you ever made yourself vomit after meals: ☐No ☐Yes
Have you ever been treated for Bulimia: ☐No ☐Yes
Have you ever been treated for Anorexia Nervosa: ☐No ☐Yes

Any other information that may be helpful:

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:
Father: _____
Mother: _____
Brother/Sister _____

River Oaks / Bellaire Beauty and Weight Loss Center

Nutritional Supplements Consent Form

Doctor Saghy Motamedy utilizes several types of nutritional supplements (such as vitamins, mineral, essential fatty y acids, herbal supplement, amino acids, Glutathione, antioxidant, etc) and medicine to improve your overall health. The method of administration of these nutritional medicines, the purpose for its administration, its potential for good and its potential for harmful side effects has been fully explained to you.

This nutritional therapy and some instrumentation may not be accepted or supported by scientific /medical literature such as AMA (American Medical Association), insurance companies and could be seen as experimental or based off anecdotal claims. The Us Food and Drug administration has not evaluated or approved nutritional or herbal treatment specifically or may recommend different treatments. However, they have been widely used in Europe and the USA for years. Many medical providers might see these types of treatments as not medically necessary.

As with drugs nutritional supplements may exhibit some side effects in some individual, may interact with certain medications or lab tests or show symptoms due to certain preexisting disease condition. Side effects may include but are not limited to pain, infections, light headedness, dizziness, diarrhea, flushing, nausea, palpitation, chest pain, muscle cramps, rash, true allergy, headache and more. Most people tolerate these vitamin shots without issue, and side effects are rare. If these occur, you should follow up with a medical provider or go to the emergency department immediately.

Whether or not these nutritional supplement/medicines is safe or effective for a specific condition depends upon the degree of likelihood of injury and or illnesses from the use of the procedures when properly administered upon the prognosis for the condition if left untreated and upon your cooperation in the foilowing of the dietary, metabolic nutrient recommendation, and rest regimen which accompanies the procedure(s). It is believed in your case that these nutritional medicines are proper under these criteria, and you will quite probably improve in the condition for which you are under treatment and in your overall health. However, you must understand that no one can or will guarantee the results of any of these therapies which may be administered to you here at River Oakes/ Bellaire Beauty and Weight Loss Center. Further because the use of these nutritional medicines is regarded as experimental for the reasons preciously cited, we cannot and do not offer this procedure/therapy to you except upon the condition you do release us from any legal responsibility for harm resulting from its use in your case. Your signature on this agreement will constitute a full and final release of our legal responsibility resulting from the administration of these nutritional medicine, in your case and or any other medical treatment which may be necessary as a result thereof.

I have read and understand the above. All questions about my use of these nutritional supplements have been answered to my complete satisfaction by the physician and or the staff at River Oaks / Bellaire Beauty and Weight Loss Center. I will indicate by my signature at the end of this form a desire to undertake such recommended therapy / therapies and agree to the above release. I understand that in case of side effects or complications I will stop the treatments and contact my primary care physician.

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Printed name **Patient Signature** **Date**

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Physician signature **Witness Signature**

River Oaks/Bellaire Beauty and Weight Loss Center

Informed Consent for Medically Management Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with River Oaks Beauty and Weight Loss/ Bellaire Beauty and Weight Loss. I hereby authorize them to evaluate me for admission into their weight management program and treat me accordingly. I certify that I am signing this under my free will and am competent to make my own medical decisions. I fully realize that entering any program involving weight reduction, which includes calorie restriction, exercise, and medications/ nutritional supplement, involves potential risks and side effects.

The risks include, but may not be limited to the following:

Palpitations, heart irregularities, tachycardia, hypertension, restlessness, insomnia, dizziness, euphoria, tremor, headaches, electrolytes imbalance, dry mouth, constipation, diarrhea, nausea, vomiting, fatigue, urticaria(rash), impotence, gallbladder stones or cholecystitis, pancreatitis. less common but more serious side effects: valvular heart disease, psychosis, heart attack, stroke and sudden death. These and other possible risks could on occasion be serious or fatal.

(Patient initial _____)

- Drug interactions may occur if other medications are taken. Being on multiple medication can increase the chance of side effects. Certain medical conditions (such as glaucoma, hypertension, and heart disease may be worsened with some of the medication prescribed on this program. If you have a history of cardiovascular disease, you do knowledge that you have had a cardiac evaluation and been cleared to start this program.

  (Patient initial----------)

- Pregnancy (Females Only). You must take precautions to avoid becoming pregnant during the course of weight loss treatment. Restricted diet and some of the medications prescribed can cause damage for the developing fetus, so you should be on contraception while under the course of treatment. **(Patient initial ----------)**

- The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 27 or higher with other medical conditions such as high blood pressure, diabetes, or high cholesterol. Some weight loss medications have been approved for 12 weeks, therefor Prescribing medications for patients not fitting these criteria or for longer than 12 weeks, is considered **"off label" and not "FDA approved**." Therefore, the potential risks vs. benefits may be great. For patients not fitting the BMI criteria or the time limit for use of appetite suppression medication, you are acknowledging that:
  a. You have put forth a true effort to lose weight through diet and exercise over the past 6 months and have still not achieved your weight loss goals.
  b. That your inability to lose weight is causing significant emotional distress
  c. You are choosing to enter this medically managed weight loss program voluntary and hold harmless (River Oaks/ Bellaire Beauty and Weight loss) for use of such medications. **(Patient initial ----------)**

River Oaks/Bellaire Beauty and Weight Loss Center

- You acknowledge that alcohol and illicit drug use is prohibited in the program. Drugs like cocaine, amphetamines, opioid when used in conjunction with some of the medications prescribed could cause in serious injury or death. The use of alcohol will also affect your results. I acknowledge that I understand that the amount of weight loss varies from patient to patient, and is, to a large extent dependent on each patient's personal motivation and commitment to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed or implied. I understand the importance of routinely following up with River Oaks/ Bellaire Beauty and Weight Loss to monitor my progress during treatment. I understand this is vital to the safety of the treatment program and certify that I will be returning biweekly/monthly as prescribed.

  (Patient initial --------)

- I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with medically managed weight loss therapy with River Oaks/ Bellaire Beauty Weight Loss Center. I release any claim in court or any type of complaint that could result from treatment with River Oaks/ Bellaire BWL center, Dr Motamedy and the staff associated with them and will not hold liable any provider or staff of River Oaks/ Bellaire BWL Center. **(Patient initial _____)**

- I acknowledge that the medically managed weight loss program recommended to me by River Oaks/ Bellaire Beauty Weight Loss is just one of multiple strategies to reduce weight. Alternative treatment options include: Diet and exercise alone without medications.
  The use of other kinds of medications to achieve appetite suppression. Non-medical weight loss programs like Weight Watchers. Bariatric Surgery.
  I understand that treatment modalities utilized by Rive Oaks/ Bellaire Beauty and Weight Loss Center might not be supported by scientific/medical literature such as AMA (American Medical Associate) or FDA and could be seen as experimental or based off anecdotal claims. Many medical providers, including endocrinologists, surgeons, family practice doctors, etc., might see these types of treatments as not medically necessary. I also understand that many of the medications/supplement being utilized within River Oaks/Bellaire Beauty Weight Loss Center medically managed weight loss program are considered to be used "off label" and might not be FDA approved for weight loss purpose.

  (Patient initial _____)

By signing below, I acknowledge that I have had an opportunity to read and fully understood this consent form and all my questions been answered to my satisfaction. I have been urged to take all times I need in reading and understanding this form and in talking with my doctor regarding risk and regarding other treatment options.

_____ _____

Signature of patient Print name Date

River Oaks/Bellaire Beauty and Weight Loss Center

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me. I certify that I am under the regular care of a primary care provider for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at River Oaks/ Bellaire Beauty and Weight Loss Center for medically managed weight loss services offered only. I acknowledge I am not wanting to establish primary care with River Oaks/ Bellaire Beauty and Weight Loss Center, and I am here for specialized care including weight loss therapy, diet counseling, exercising counseling.

- **(Patient initial----------)**

Regaining Weight Acknowledgement:

There is a Risk of Regaining the Weight you have lost if you don't follow a healthy diet during your maintenance. Obesity is a chronic condition, and most overweight individuals who lose weight have a tendency to regain all or some of it back over time not following a low-calorie diet. Factors which favor maintaining weight loss include exercise, adherence to a calorie that is low-calorie, nutritious, and full of lean proteins and vegetables. Successful treatment may take months or even years. Utilizing medications to assist you in your weight loss goals in addition to diet and exercise could prevent from weight coming back. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose.

_____

Signature of patient Print name Date

Physician: I have explained the contents of this document to the patient, and I have answered all the patient 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 the appetite suppressant, the benefits and the risks associated with the alternatives therapies and the risk of continuing in an overweight state. After being adequately informed the patient has consented to therapy involving the diet medications/ supplements indicated.

Physician Signature----------Date----------