Wellness. Your Goal. Our Mission.

Health Centered
SPINE & WELLNESS GROUP

Patient Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Email address _____ Cell Phone _____

DOB _____ Age _____ M F SS# _____ Marital Status: M S D W

How did you hear about our office? **Newspaper Radio Internet Friend Physician Health Fair Other**

Circle: Employed FT Employed PT Self Employed Homemaker Retired Unemployed due to pain Unemployed for other reasons

Employer _____ Employer's Address_____

Work Phone _____ Type of Work_____ # of Hours Worked per Week _____

Spouse Name _____ Name/Ages of Children _____

Name of Emergency Contact _____ **Relationship** _____

Emergency Contact Phone Number _____ **Cell Phone Number** _____

Responsible party/ Parent/ Guardian (if different from above) Name _____

Address _____ City _____ State ____ Zip _____ DOB_____

Employer _____ Address_____ Work Phone _____

Weight History:

When did you first become overweight? (your age then) _____ / (year) _____

How did your weight gain start? Describe any circumstances:

_____

What do you think is the cause of your weight problem: _____

Your present weight: _____ your weight goal: _____ height: _____

What was your highest weight? (excluding pregnancy) _____your age then _____ # of years ago: ____

What was your lowest weight? _____ your age then _____ # of years ago: _____

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? Yes/No Most lbs lost: _____ How long it took: _____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:

_____

_____

Where and when do you do most of your overeating? _____

Please make any comments that you think might be helpful to help in your weight management:

_____

Do you currently have any medical concerns? Please List:

_____

Referred By: _____

HEALTH HISTORY

ALLERGIES (Medications, Food, Bee Stings, Etc…)

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS

Drug Name	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic	Psychiatric
○ Frequent Sneezing ○ Hives ○ Itching ○ Runny Nose ○ Sinus Pressure	○ Fatigue ○ Increased Thirst/Hunger/Urination	○ Easy Bruising/Bleeding ○ Swollen Glands	○ Alcohol Overuse ○ Anxiety/Stress ○ Depression ○ Do Not Feel Safe in Relationship ○ Mania ○ Sleep Problems
Cardiovascular	**Gastrointestinal**	**Integumentary (Skin)**	**Respiratory**
○ Arm Pain on Exertion ○ Chest Pain on Exertion ○ Chest Heaviness/Pressure on Exertion ○ Irregular Heart Beats (Palpitations) ○ Light-headed on Standing ○ Shortness of Breath when lying down ○ Shortness of Breath when walking ○ Swelling (Edema)	○ Abdominal Pain ○ Black or Tarry Stool ○ Blood in Stool ○ Change in Appetite ○ Frequent Indigestion ○ Hemorrhoids ○ Trouble Swallowing ○ Vomiting ○ Vomiting Blood	○ Changes in Moles ○ Dry Skin ○ Eczema ○ Growth/Lesions ○ Itching ○ Jaundice (Yellow Skin/Eyes) ○ Rash	○ Cough ○ Coughing Up Blood ○ Shortness of Breath ○ Sleep Apnea ○ Snoring ○ Wheezing

Constitutional ○ Exercise Intolerance ○ Fatigue ○ Fever ○ Weight Gain (___lbs) ○ Weight Loss (___lbs)	**Musculoskeletal** ○ Back Pain ○ Joint Pain ○ Muscle Aches ○ Muscle Weakness	**Eyes** ○ Dry Eyes ○ Irritation ○ Vision Change Date of Last Exam: _____	
Ears/Nose/Mouth/Throat ○ Bleeding Gums ○ Difficulty Hearing ○ Dizziness ○ Dry Mouth ○ Ear Pain ○ Frequent Infections ○ Frequent Nosebleeds ○ Hoarseness ○ Mouth Breathing ○ Mouth Ulcers ○ Nose/Sinus Problems ○ Ringing in Ears	**Neurological** ○ Dizziness ○ Fainting ○ Headaches ○ Memory Loss ○ Migraines ○ Numbness ○ Restless Legs ○ Seizures ○ Weakness	**Genitourinary** ○ Blood in Urine ○ Difficulty Urinating ○ Incomplete Emptying ○ Increased Urinary Frequency ○ Urinary Loss of Control	

PAST MEDICAL HISTORY

Please check all that apply: ○ Anxiety Disorder ○ Arthritis ○ Asthma ○ Bleeding Disorder ○ Blood Clots (or DVT) ○ Cancer ○ Coronary Artery Disease ○ Claustrophobic ○ Diabetes - Insulin ○ Diabetes – Non-Insulin ○ Dialysis	○ Diverticulitis ○ Fibromyalgia ○ Gout ○ Has Pacemaker ○ Heart Attack ○ Heart Murmur ○ Hiatal Hernia or Reflux Disease ○ HIV or AIDS ○ High Cholesterol ○ High Blood Pressure ○ Overactive Thyroid	○ Kidney Disease ○ Kidney Stones ○ Leg/Foot Ulcers ○ Liver Disease ○ Osteoporosis ○ Polio ○ Pulmonary Embolism ○ Reflux ○ Stroke ○ Tuberculosis ○ Other

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*WOMEN ONLY - OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear: _____ ○ Abnormal Last Mammogram: _____ ○ Abnormal Age of first menstrual period: _____ Date of last menstrual period or age of menopause: _____ Number of Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____ ○ Cesarean sections If yes, number: _____	○ Bleeding between periods ○ Heavy periods ○ Extreme menstrual pain ○ Vaginal itching, burning or discharge ○ Wake in the night to go to the bathroom ○ Hot flashes ○ Breast lump or nipple discharge ○ Painful intercourse	

FAMILY HEALTH HISTORY

Grandmother (Maternal)	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Grandfather (Maternal)	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Grandmother (Paternal)	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Grandfather (Paternal)	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Father	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Mother	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○Arthritis ○Depression ○Cancer ○Diabetes ○Genetic disease ○Heart Disease ○ Hypertension ○Osteoporosis ○Stroke ○ Scoliosis

Health Centered
SPINE & WELLNESS GROUP

Our Financial Policy

Thank you for choosing Health Centered Spine and Wellness Group as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our New Patient Information form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, MASTERCARD, AND VISA.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and the fees that we charge are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment of cash at the time service has been verified.

Interest

We reserve the right to charge interest in the amount of 9% monthly as provided by state law. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Terms of Sales

All sales are final. You are entitled to a full refund within 7 days of the purchase of your content or services if you have not used any products or services. HCSW does not provide a refund on any services if you have used any of the services.

Missed Appointments

ALL APPOINTMENTS must be cancelled within 24 HOURS of the appointment or we reserve the right to charge $25 as a MISSED APPOINTMENT CHARGE.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ DATE _____

Signature of Patient or Responsible Party

X _____ DATE _____

Signature of HCSWG Employee

HIPAA Notice of Privacy Policies

Health Centered Spine & Wellness Group

600 S. Jackson Park Drive Seymour, IN 47274 812-519-2963
905 W, Keegan's Way, Greensburg, IN 47240 812-663-7640

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPPA Notice Cont.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at all alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to Object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 812-519-2963 or 812-663-7640.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____	_____	_____
Signature	Print Name	Date

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO OTHER PERSONS AND/OR LEAVE MESSAGES

It is the policy of Health Centered Spine and Wellness Group to not release confidential patient information about you, unless it is for the patient care and treatment, payment, or operations. If you wish for our physician and/or office staff to leave messages for you on your home voice mail, work telephone, cell phone or to any other person, then you must complete the following:

I authorize Health Centered Spine and Wellness Group to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my physician or office staff whenever I want this to change:

We can call your home?	Yes	No
We can leave a message on your home voice mail?	Yes	No
We can call you at work?	Yes	No
We can leave a message on your cell phone?	Yes	No
We can fax copies of information to other offices if necessary?	Yes	No

Please list the names of people and their relationship to you, if you wish us to release confidential patient information to them:

Name **Relationship (spouse, parents, friend, neighbor)**

_____

_____

_____

_____ / _____ _____ / _____

Patient Signature/Legal Representative **Date** **Witness Signature** **Date**

CONSENT FOR CARE

As a patient of Health Centered Spine & Wellness Group, I give the providers permission and authority to care for me or the above named minor in accordance with tests, diagnosis, and analysis. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever the patient is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the provider. The Provider provides a specialized, non-duplicating health care service.

I understand that if I am accepted as a patient by a provider at Health Centered Spine & Wellness Group, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding treatment, will be explained to me upon my request.

I hereby give my consent for evaluation and treatment to Health Centered Spine and Wellness Group. In the event the patient is a minor, I hereby consent to treatment of the minor patient.

_____ _____

Signature of Patient/Guardian Date

Health Centered Spine & Wellness Group
Weight Management Center
Seymour: (812) 519-2963 Greensburg: (812) 663-7640
HealthCentered.net

Thank you for taking the time to read about what Health Centered Weight Loss can do for you. You will be amazed at the results you can achieve if you put your mind and body to it.

- The front office asks that you sign a weight loss label along with the time you arrived in the main lobby. You will be asked to have a seat in the main lobby until you are called back.
- You will need to complete paperwork the day of your consultation.
    - General information needed, medical history, consent forms, and a Treatment Agreement plan
- The consultation is free, unless you choose to join one of our programs (prices do vary from $155-$700 – will be covered in consult)
    - If you chose to join and pay the day of your consult you will be paying for:
    - Health FITspiration Packet, Low Glycemic Diet Book, medication, an appointment to see the physician, 1 LipoTropic injection to increase loss of unwanted body fat, and weekly weigh -in visits.
    - If you would happen to miss two prescription pick-ups in a row, it voids the remaining prescriptions you have. In this case, you would have to restart and see the doctor again for a new 3-month Rx. You will be paying for your prescription and Doctor visit. You will also receive 1 LipoTropic Injection.
- We are a medical office, in order to start/restart a program, or to renew your medication, you must see the physician – NO EXCEPTIONS
- You **DO NOT** have to make an appointment to come in to pick up your medication, to weight in, or to get a LipoTropic injection.
    A. Greensburg: Tuesday and Thursday's ONLY for medication pickups
    B. Office Hours are given on the back of this paper.
- We will send you a text to remind you that it is time to pick up your prescription. Please let us know of any phone number or address changes.
    - If you receive a text message from us, it is important information, you will need to know – **READ ALL OF THE TEXT MESSSAGE**
- We do not have you to sign a contract here. Your program may need to change from time to time, and we are here to help you and to develop a program just for you. We understand sometimes life can get in the way and we want to reassure you that we are here for <u>YOU</u> for every step of the way. **Communication is the key.**
    - We will have you sign a Treatment Agreement and Your Treatment Plan consent, you will also get a copy of each to use as a reference
        - If you are not compliant with any of our policies, agreements, plans, and or program – it could result in a temporary or permanent dismissal from all Weight Management Programs. The physicians want you to take weight management seriously.
    - You will be on a 1250 calorie Low Glycemic Diet Plan (Depending on your physical activity, we will adjust to your individual needs).
    - We have provided you with information in this packet that you will need to be successful at losing weight.
- You will be responsible for your weight loss each month by following the meal plans and snacks from the diet book you received. The management book is part of the program.
        - You pick your meals from the diet book, but you can get recipes from our Facebook and Pinterest page to change things up every occasionally
- Losing weight isn't easy, but to continue being a loyal and compliant patient, the physician requires consistent weight reduction each month to prescribe medications to you month after month
        - 1st time not showing consistent weight reduction--Results in a warning
        - 2nd time, you will have to see the physician for a reevaluation - $40 physician visit will be applied
- We must have a copy of your CBC, CMP, A1C, and TSH (thyroid) lab test
        - We are a physician-based program. We are checking for several things (Blood, diabetes, electrolyte levels, thyroid, and kidneys) to determine the best way for YOU INDIVIDUALLY to manage your weight.
        - These labs must be completed within 30 days of starting the program
        - We will schedule a day and time to come in for the test OR if you've had these tests done in the last year, we will accept that, just bring us a copy of the results. We will draw a basic test here (included in New Patient Packages) or we can write you an order to get it done at your doctor's office.
        - We will need this lab taken each year.

- We recommend taking a 1 multi-vitamin per day, 2000 mg Vitamin C per day, and 800 Iu Vitamin E per day.
- We would also like to remind you that for every individual you refer that signs up for a program, you qualify for the Loyal Patient Package. This will get you 50% off of your next month prescription and 1 free LipoTropic Injection. There are a few stipulations for this package. There is more information in your New Patient packet or you can visit our website for more information – HealthCentered.net
- You do have to see the physician every 3 months to renew your prescription – Please refer to the Controlled Substance Policy
- A $25 fee will be applied to your bill and will need to be paid before any services are provided if
    - If you no call no show for an appointment
    - Canceling your appointment after the time allotted for you to cancel your appointment – please refer to the Missed Appointment Policy and Appointment Cancellation Policy
- We do have a LipoTropic Injection package: 4 shots for $120, 8 shots for $220 or 1 for $35. We do run specials on our LipoTropic Injection from time to time and advertise ALL our sales on our Facebook page – Health Centered Spine and Wellness and on our website – HealthCentered.net
    - You can get up to 2 injections per week, but one is more than sufficient.
    - You do not have to make appointment for an injection.

Seymour Hours

Open Walk-in Business Hours

Monday, Tuesday, Thursday: 8:00 am-6:00 pm

Wednesday: 8:00 am-12:30 pm
Wednesday: **Doctor Day** 1:00 pm-6:00 pm **(Doctors Appt. Only*)**

Friday: 8:00 am-12:00 pm

Greensburg Hours

*All prescriptions must be picked up on **Tuesdays or Thursdays ONLY***

Monday: 8:00 am -4:00 pm (Injections & Weigh-ins)

Tuesday: 8:00 am-4:00 pm (Injections, Weigh-ins, & **Prescription Pick-ups**)

Wednesday: 8:00 am-4:00 pm (Injections & Weigh-ins)

Thursday: 8:00 am-12:00 pm (Injections, Weigh-ins, & **Prescription Pick-ups**)

Thursday: ***Doctor Day*** 1:00 pm-6:00pm (**Doctors Appt. Only***)

Friday: CLOSED

THESE DAYS AND TIMES ARE SUBJECT TO CHANGE

*If you come in during Doctor day, you will be asked to come back during our regular business hours. It is not that we don't want to see you, but we just don't have time to see walk-in patients and patients with appointments during this time. Thank you for your understanding and cooperation.

- **It is your, the patient, responsibility to read the information in your New Patient Packet and Diet Book. There is too much information to go over everything in the consultation. Please ask us questions if you do not understand something, we will be more than happy to assist you.**

Updated 1/1/18

Patients Signature: _____ Date: _____

Consulted By: ____Chelsea Stroub_____ Date: _____

Doctor Sign: ____Andrea Keane, NP / Laverne Loehr, WHCNP___ Date: _____

Health Centered Spine and Wellness
Weight Management Clinic
HealthCentered.net

Treatment Agreement

The standard Health Centered Weight Loss's diet program consists of the following:

- ✓ Prescription of Phentermine, Ionamin, Fastin, or Adipex
- ✓ Drinking your recommended daily intake of water (for your personal need)
- ✓ Exercise, at least 3 – 4 times per week for 30 minutes each time
- ✓ 1250 calorie (Females) 1400 calorie (Males) Low Glycemic Diet
- ✓ Losing weight isn't easy, but to continue being a loyal patient, the physician requires a consistent reduction in your weight each month in order to prescribe medications to you month after month, if you do not the following will take place:
    - 1st time = Warning -- We will talk & try and figure out potential issues going on
    - 2nd time = Physician appointment will be required to continue, there will be a $40.00 visit fee due at the time of service.

    - If you are unable to make an appointment, please refer to the Appointment Cancellation Policy.

We do need Labs taken– (CBC, CMP, TSH, and A1C) We can do it here in the office for $75 or you can have your doctor's office to do it and have them to fax us a copy or you can bring us a copy. This must be completed within 30 days of starting or restarting a diet program. It is to be done once a year also. We will schedule a day and time to come in.

If you do not come and pick up your prescription two months in a row, it will be returned to the pharmacy. Therefore, the remaining prescriptions you have will be void. To receive another prescription of Phentermine you will restart the program and schedule an appointment to see the Doctor and pay $120.

If you cannot follow the rules and regulations put into place by HCSW, you will need to make an appointment to see the physician. This would require a $40 doctor visit fee.

By signing the agreement, you understand and are willing to abide by these rules and regulations.

X_____ Date_____

Effective as of August 31, 2016 Update 1/1/18

Health Centered
SPINE & WELLNESS

Controlled Substance Policy

This change will take effect 01/01/2017

The requirement for controlled substance prescriptions, by the state of Indiana, is the patient must see the prescribing physician every 3 months.

Weight Management Patients on a Phentermine program will be scheduled to see the physician no less than every 3 months, even patients on a maintenance program.

We will schedule in an advance for your 3-month check-in with the physician.

(Please refer to the Appointment Cancellation Policy)

By signing this policy: you are stating you have read, understand, and agree to follow this policy

X_____ Date _____

X_*Andrea Keane, FNP-C, Laverne Loehr, WHCNP*__ Date _____

LIPOTROPIC INJECTIONS INFORMED CONSENT

I have been informed of the following:

- While all components generally have no side effects, doses must be taken at regular intervals. The injections are only effective temporarily. As soon as the effect of these drugs wear out, the body starts returning to normal.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people have experienced allergic reactions to the injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys. Some patients have been unable to control their urine and/or had diarrhea.
- Depression is another possible side effect.
- It has been reported that B12 can cause peripheral vascular thrombosis, itching, and a feeling of swelling in the body.
- Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pains.
- Lipotropic injections change the function of the digestive system temporarily. This can result in extreme exhaustion.
- Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.
- Vitamin B12 is contraindicated in Leber's hereditary optic neuritis, as it can cause blindness.

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

I have read the above and I agree to accept the risk of the procedure. All my questions have been answered to my satisfaction. I agree to release the facility and the medical practitioner from any liability arising from the procedures. I consent solely to arbitration as a legal means of settlement.

Client: _____ Date: _____

Print Name: _____

Practitioner: _____ Date: _____

PHENTERMINE WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through NP, V. Laverne Loehr/Andrea Keene. I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. NP, V. Laverne Loehr/Andrea Keene can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand NP, V. Laverne Loehr/Andrea Keene can only prescribe Phentermine and medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalessemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure. Initials: _____

Contraindications and Warnings –

Patients with the following should not use Phentermine:

- An allergy to Phentermine
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or glaucoma
- Are in an agitated state or have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant

Patients with the following should take special precautions and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or high cholesterol or lipid levels

Side Effects –

While Phentermine is generally free of negative side effects, there is the possibility of the following:

- Dry mouth
- Unpleasant taste
- Heartburn
- Skin Rash or Itching
- Diarrhea
- Constipation
- Stomach Pain
- Lactic acidosis
- Nausea/ Vomiting
- Fatigue
- Hypertension
- Insomnia or Restlessness

Less common side effects include:

- Convulsions (Seizures)
- Panic attacks
- Tremors or shaking
- Erectile Dysfunction
- Fever
- Fainting
- Depression
- Hallucinations
- Overactive reflexes

I understand Phentermine treatments may involve these risks and other unknown risks: Initials: _____

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform NP, V. Laverne Loehr/Andrea Keene if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. Initials: _____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this. Initials: _____

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact NP, V. Laverne Loehr/Andrea Keene immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility. Initials: _____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise NP, V. Laverne Loehr/Andrea Keene at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by NP, V. Laverne Loehr/Andrea Keene for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. Initials: _____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient's Name Printed: _____

Patient's Name Signed: _____ Date: _____

Provider's Name Printed: _____Velma Laverne Loehr, FNP-C, Andrea Keane, FNP-C_____

Provider's Name Signed: _____ Date: _____