Patient Registration Form

Age _____ Male / Female

Patient's Last Name _____ First Name _____

Date of Birth _____ Last 4 SS# _____ Race _____ Height _____

Email Address _____ Cell Phone _____ DMV ID #_____

Address on ID _____

Current Address _____

Known Allergies _____

Known Illnesses _____

Medications Taken in last 90 days _____

Reason For your Appointment _____

Your Current Weight _____ Pant/Skirt Size _____ Shirt / Top Size _____

Your Stress Level _____, Exercise Level _____ Number meals per day _____

I, the undersigned patient, confirm that the information provided in this page is correct and know that (a) the clinician will use this information to help me design my care (b) the facility uses several clinicians of their availability (c) the facility and clinicians do not accept any health insurance for payments (d) I am responsible to pay for the (1) facility charges management fee (2) Clinician fee (3) Medications (4) supplements and all other services received.

Patient Signature _____ Date _____

Medical Weight Loss Program Enrollment
Consent Form And Agreement

I the undersigned patient. Being of sound mind and body. Have received and understood the available information about the medical weight loss program and am signing this consent and agreement to enroll in the program willfully and voluntarily.

I recognize that the diet and exercise alone are not enough for me to reduce my weight and I understand that the benefits of the medication prescribed to me and its effect on my health out weight the potential risks these medication use if used as prescribed.

I confirm that I have been advised by my clinician the benefits and side effects of the prescribed medication may produce. And further advised that if side effects are realized. I'm to immediately cease using medication and call clinic/weight/loss center.

I have also been advised that if a schedule III or IV controlled substance is prescribed or dispensed to me i will follow the PART 80.71 rules and regulations of New York State. Some which are as follows:

a) I will use the drugs or short term under strict medical supervision. Means that i may not be dispensed more than 30 day supply of medication.
b) I will keep the medication in a suitable and durable container with the original typed. Or printed or legibly written orange label. The affixed label should not be altered or removed until the medication bottle is empty.
c) A maximum of 30 days of the schedule III or IV will be prescribed or dispensed and under no circumstances the same can be filled earlier than 5 days of its due date.
d) Under no circumstances shall any person: obtain or attempt to obtain a prescription for controlled substance or attempt to procure the administration of controlled substance by fraud. Deceit. Misrepresentation or subterfuge by use of a forged or altered prescription or the concealment of material fact. By the use of a false name or the giving of false address or go to other practitioner to obtain the similar medication
e) Its is unlawful for any person to sell or furnish. To any other person or persons. Controlled substance prescribed or dispensed to him in the course of treatment. Is supplied with supplied during such treatment with controlled substance or prescription thereof by us and who without disclosing the fact. Is supplied during such treatment with controlled substance or prescription thereof by another clinical shall be guilty of violation of this part.

Initial ____/____

Contraindication for use of these drugs are known: hypersensitivity or idiosyncratic reactions to sympathomimetics. Advanced arteriosclerosis. Symptomatic cardiovascular disease. Moderate and severe hypertension. Pulmonary hyperthyroidism and glaucoma. Highly nervous or agitated.

If you are taking any CNS stimulants. Including monoamine oxidase inhibitors or other amorectic's agents.

** You must disclose all current medications or substances you are using to the prescribing physician. Failure to do so will be deemed a breach under this agreement and can disqualify you from treatment under the Medical Loss Program.**

Over dosage: acute overdose with Appetite suppressants may manifest itself by the following signs and symptoms: unusual restlessness. Confusion. belligerence . hallucinations and depression usually follow stimulation. Cardiovascular effects include arrhythmias. Hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea vomiting diarrhea and abdominal cramps.

By signing this form. I'm fully aware that the prescribing clinic can refuse to refill my prescription if they deem non-compliance by me associated with this agreement.

The theft of Loss of Controlled substance should be promptly notified to the local authorities such as the police department.

Failure to abide by the terms and disclosures of this agreement shall expressly indemnify the clinic its assignees where applicable for any liability with resulting in loss on damage as a result of non-compliance.

Signature _____

Print Name _____

Date _____

I hereby certify that the patient has signed this consent and agreement in my presence after all his/her questions were answered.

physicians/NP/PA Signature _____ Print Name_____