10234 US Hwy 36 Avon, IN 46123 | fastclinicalweightloss.com | 317-384-1003

Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

DOB: _____ Age: _____ Sex: M/F

Email Address: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No.: _____ Ext. _____

Social Security No.: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: Yellow Pages Internet Mail Friend: _____(Circle all that apply)

Midwest Center for Healthy Living
(Fast Clinical Weight Loss)
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Midwest Center for Healthy Living** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Midwest Center for Healthy Living** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Midwest Center for Healthy Living** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Dr. Gregory Oliver, 10234 E US Highway 36, Avon, IN 46123.**

With this consent, **Midwest Center for Healthy Living** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Midwest Center for Healthy Living** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **Midwest Center for Healthy Living** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Midwest Center for Healthy Living** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Midwest Center for Healthy Living** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Midwest Center for Healthy Living** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient’s Name Date

Print Name of Patient or Legal Guardian, if applicable

MIDWEST CENTER FOR HEALTHY LIVING, LLC

Weight Loss Program Consent Form

I _____ authorize **Dr. Oliver** and whomever is designated as his assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(or person with authority to consent for patient)

Financial Policy:

Thank you for selecting Dr. Oliver for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover and Health Savings Account cards.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all the above and have agreed to these statements.

_____ _____
Patient's Signature Date

No Show Policy

A "no show" is defined as a patient who misses an appointment without cancelling in a minimum of 24 hours in advance for all provider appointments. A failure to be present at the time of an appointment will be recorded in the patient charge as a "no show." This includes arriving more than 15 minutes after the scheduled appointment time. In the event of a "no show" Fast Clinical Weight Loss "may" charge the patient a $25 missed appointment fee. This fee "may" be charged for missed appointments or appointments cancelled in less than 24 hours' notice. We allow two no show appointments before considering a patient for termination from the practice. Those arriving more than 15 minutes late to their appointment may be asked to reschedule.

By signing this statement, I acknowledge that I understand and agree to abide by the terms of the Missed Appointment Policy

_____ _____
Patient's Signature Date

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MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Name of Primary Care Provider (PCP): _____

Current/Past Specialty Providers: _____

List your top 3 concerns for today's visit:

_____

_____

_____

Allergic To:	Reaction

Allergic to: Latex: ☐ Yes ☐ No Lidocaine: ☐ Yes ☐ No Betadine: ☐ Yes ☐ No

Medication	Dose	Reason for taking	Prescriber

Preferred Pharmacy: _____ **Address:** _____ **Phone** _____

Past Medical History:

_____

_____

_____

GYN History (female):

Age of first menses: _____ First Day of last menses: _____

How many pregnancies: _____ Live births: _____ Miscarriage/Abortions: _____

Current Method of birth control: _____

If Menopause, Age: _____ Year _____

Previous endometrial ablation? _____ Previous hysterectomy? _____ Ovaries removed? _____

_____ _____ _____

GU History (Male):

History of impotence, BPH, prostate cancer or testicular cancer? If so please explain:
_____
_____
_____

Males/Females:

Any current or previous treatments with hormones? YES/NO If yes, describe including positive or negative
effects_____
_____
_____
_____

Preventative Health History: Please enter dates of most recent and details if abnormal.

Preventative Test	Date	Normal	Abnormal	History of Abnormal Details
PAP				
Mammogram				
Bone Density				
Colonoscopy				
Rectal Exam				
PSA				
Chest X-Ray				
EKG				
Exercise Stress Test				

Tetanus Vaccine: _____ Flu Vaccine: _____ Pneumonia Vaccine: _____

Tuberculosis Test: _____ Hepatitis Vaccine:_____ HIV Test: _____

Surgical and Hospitalization History:

_____

_____

_____

Family History:

List family members with the following health conditions. Please circle if cause of death.

☐ Heart Disease: _____
☐ Heart Attack before age 50: _____
☐ High Blood Pressure: _____
☐ Diabetes: _____
☐ Thyroid Disorder: _____
☐ Mental Illness: _____
☐ Genetic Disorder: _____
☐ Breast Cancer: _____
☐ Ovarian Cancer: _____
☐ Colon Cancer: _____
☐ Other: _____

Tobacco Use circle one, add details if needed

☐ **Has never smoked tobacco**

☐ **Former Smoker:** Year quit _____ Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

☐ **Current Smoker:** Desire Quitting? ☐ Yes ☐ No Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No if yes, how many drinks per week? _____

Do you have previous or current problems with alcohol? _____

Substance abuse:

Recreational drug use? ☐ Yes ☐ No Details _____

Prescription drug abuse? ☐ Yes ☐ No Details _____

REVIEW OF SYSTEMS (ROS): circle all that apply

CONSTITUTIONAL: chills, fatigue, fever, weight change

EYES: blurred vision, eye pain, photophobia

E/N/T: hearing problems, congestion, rhinorrhea, epistaxis, dental problems

CARDIOVASCULAR: chest pain, palpitations, fast heart rate, shortness of breath, edema

RESPIRATORY: cough, painful breathing, coughing blood

GASTROINTESTINAL: abdominal pain, heartburn, constipation, diarrhea, stool changes

GENITOURINARY: genital lesions, blood in urine, urinary frequency, painful urination, decreased libido

Female: abnormal vaginal discharge, abnormal vaginal bleeding, irregular menses, heavy menses

Male: erections less strong, difficulty urinating

MUSCULOSKELETAL: joint pain, back pain, muscle aches, decrease in strength or endurance, loss of height

INTEGUMENTARY/BREAST: atypical moles, dry skin, itching, rashes, breast mass, nipple discharge

NEUROLOGICAL: dizziness, headaches, numbness/tingling, weakness

HEMATOLOGIC/LYMPHATIC: easy bruising, easy bleeding (not due to medication), swollen lymph nodes

ENDOCRINE: hair loss, heat/cold intolerance, excessive thirst, excessive hunger, hot flashes, night sweats

ALLERGIC/IMMUNOLOGIC: allergies, frequent illnesses, HIV exposure, hives

PSYCHIATRIC/SLEEP: anxiety, depression, sleep disturbances, mood changes, irritability