Patient Demographic Form

Last Name: _____First Name: _____Middle_____

Address:_____ City: _____ State: _____Zip Code: _____

Telephone: Home: _____ Work: _____Cell: _____

Date of Birth: _____ Age:_____Sex: F__ M__ Email:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

SS#: _____Employer:_____Occupation:_____

Spouse's Name: _____Phone:_____Date of Birth:_____

Emergency contact: _____Phone:_____Relationship:_____

Family Doctor Name/Address: _____Phone: _____

Pharmacy Name/Address: _____Phone: _____

How were you referred: □ TV INS □ YP RADIO □ FRIEND □ INTERNET □ OTHER _____

(DO NOT FILL OUT INSURANCE SECTION BELOW FOR WEIGHT LOSS OR AESTHETICS SERVICES)

INSURANCE INFORMATION

Primary:_____ Secondary:_____

Address:_____ Address:_____

Phone: _____ Phone:_____

ID#:_____Grp#_____ ID#:_____Grp#_____

Insured Name: _____DOB:_____ Insured Name: _____DOB:_____

NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Understanding Women and/or Thomas Laser Center for all services rendered. I hereby authorize Understanding Women and/or Thomas Laser Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed:_____Date_____

Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee**. We will submit for the Physician and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a $40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a $50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

REFUNDS FOR AESTHETIC SERVICES: All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

PRODUCTS PURCHASES: Products are Non-Refundable or Exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient's request.

_____ _____ _____

Print Name Signature of responsible party Date

Patient Communication Authorization

Patient's Name: _____ Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

_____ Home phone number Leave a message: __ yes __no

_____ Mobile/Cell number Leave a message: __ yes __no

_____ Work phone number Leave a message: __yes __no

_____ Call only this number. _____Leave a message: __yes __no

_____ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____ Date_____

MEDICAL HISTORY

Patient Name: _____Marital Status:_____ Age_____D.O.B:_____

Reason for today's visit:_____

DrugAllergies:_____

Are you allergic to Latex: __ Yes __No Hepatitis: __Yes __No HIV: __Yes __No

Past Medical History
__Hypertension
__Diabetes
__Long term steroid use
__ Seizures
__Heart disease
__Stroke
__Cancer
__Cholesterol disorder
__Thyroid disease
__Kidney disorder
__Bleeding disorder
__Lupus/Autoimmune Dis
__Gout
__Other_____
_____

Past Surgical History/Year
__Gallbladder _____
__Hemorrhoids _____
__Hysterectomy _____
__Heart Surgery _____
__Pace maker _____
__Defribulater _____
__Prostate _____
__Bowel Surgery _____
__Tubal ligation _____
__Thyroid Surgery _____
__C-section _____
__Bariatric Surgery _____
__Cosmetic(type)_____
__Other_____

Family History (Family Member (Immediate))
__Heart Disease _____
__Breast Cancer _____
__GYN Cancer _____
__Blood clots in lungs or legs _____
__ Colon/Bower Cancer _____
__ Stroke _____
__ Prostate Cancer _____
__Other_____ _____
_____
_____
_____
_____
_____

Current Medication/Vitamins Name/Dosage
__SEE LIST
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History:
__Other_____ Tobacco use: __Everyday __Some days __Former__ Never

Chief Complaint and Review of Systems
__Abdominal pain
__Anal itch
__Anal pain
__Anal warts
__Anemia
__Bladder control problems
__Breast mass/discharge
__Constipation
__Fatigue/tired/sluggish
__Heavy vaginal bleeding
__Hemorrhoids
__Menopausal symptoms
__Painful periods
__PMS
__Rectal bleeding
__Rectal drainage
__Screening Colonoscopy
__Unable to hold bowels
__Unable to hold gas
__Vaginal discharge
__Other_____
_____
_____

GYN History:
How many pregnancies: _____
Are you pregnant: _____
Do you plan to become pregnant: _____
Are you breast feeding: _____

Date of last:
Menstrual Period:_____
Pap Smear:_____
Abnormal Pap:_____Result: __normal __abnormal
Treatment: __burning __freezing __laser
Colonoscopy:_____Result: __normal __abnormal
Pelvic US:_____Result: __normal __abnormal
Endometrial Biopsy:_____Result: __normal __abnormal
Bone Density Scan:_____Result: __normal __abnormal
Mammogram:_____Result: __normal __abnormal

_____ _____
Signature Date

OFFICE USE ONLY

HT:_____ WT:_____ HGB:_____

BP:_____ P:_____ PREG TEST:_____

DIET HISTORY QUESTIONNAIRE

Patient Name_____ D.O.B_____

How many years have you suffered with weight issues? _____
Are you motivated for a weight loss program? YES / NO
If so, how much weight do you want to lose?_____
What size would you like to get back to?_____
What is your starting weight? _____ Goal weight:_____ Height
Can you forego eating out for 3 weeks? YES / NO
What date would you like to begin the diet? _____
Do you think you can do anything for 3 weeks? YES / NO
Can you forego alcohol/beer/wine/spritzers, etc. for 3 weeks? YES / NO
Do you or have you used laxatives? YES / NO
Have you been dieting or restricting calories?_____
If so, how long?_____
Prior use of HCG? YES / NO If so, how long ago? _____
How much did you lose using HCG? _____ Did you complete the program? YES / NO
What other diets have you tried?_____
When was the last time?_____
Why did they fail?_____
Do you yo-yo diet?_____
How many times a week do you eat fast food?_____
How many sodas do you drink in a day?_____
How much alcohol do you consume in a week?_____
What is your weakness, chips/snack foods or sweets?_____
What is your comfort food?_____
Are you a vegetarian or vegan? YES / NO
Do you have any special dietary requirements? _____
Do you exercise? YES / NO If so, how often and what form of exercise do you enjoy?
_____
If not, why?_____
Are your family/friends supportive OR do they try to sabotage your efforts?_____
_____
What do you do for entertainment?_____
_____
Do you have a buddy or colleague or group of people that you can do this with? It's much easier if you do this with someone else and have a support system. YES / NO

COMMITMENT CLAUSE

DO NOT DO THIS PROGRAM IF...you are just going to treat this as if it is a fad diet. This is not another diet fad. The only reason this works is the HCG…period. If you try the Fat Burning Food Plan (FBFP) WITHOUT HCG, you will have the shakes and be faint and famished within 3 days. With the HCG, you body consumes the excess fat for food and you rarely get the shakes, feel faint or feel famished (until you get immunity or lose ALL excess fat). You may feel hungry as you stomach shrinks. You can then eat a tomato or a cucumber or an apple or an orange. This may delay the goal weight by a day (maybe, maybe not), but at least you are eating healthy, approved foods.

DO NOT DO THIS PROGRAM IF...you are not going to do it at least 21 days or travel frequently. IF you don't do this diet for 21 days, you hypothalamus is NOT reset and you will just gain back all the weight. Your body won't keep track of the fat storage until after 21 days.

Patient Name_____ D.O.B_____

DO NOT DO THIS PROGRAM IF...you think you can just try it out and see if it works for you. You have to be committed to this. It isn't easy. It is harder than other diets because it takes a commitment to both eat exactly as the method dictates AND take the medicine. What is easy about this diet, is the weight loss. If you follow the rules AND take you HCG, the pounds come off and stay off.

DO NOT DO THIS PROGRAM IF...you are <u>not</u> going to be completely dedicated to following the VERY STRICT rules. I can't say this enough - NO, you can't eat carbs (other than the melba toast). NO, you can't keep drinking regular soda. NO, you **CANNOT** substitute your favorite (steak, vegetable, fruit, beverage, seasoning) for the items on the allowed list. If you do this protocol half heartedly and with no commitment, you not only WILL fail, but since you failed, everyone around you watching with hope, will think this doesn't work, when in truth it was you, who by not following the protocol, didn't work.

DO NOT DO THIS PROGRAM IF...you don't believe you can survive on restricted caloric intake, no matter how heavy you are to start out. Some people think, "Well I am bigger," or "I require more food than the average person." Well, you are wrong. All the food you need is around you waist. The bigger you are, the more you have. The more you need, the more is available - right there, around your waist. The FBFP is meant to give you protein for muscles and quick energy for your brain and also keeps your normal fat stores topped off. Just as the daily dose of HCG is the same in all cases, so the same diet proves to be satisfactory for a small elderly person of leisure or a hard working muscular giant. Under the effect of HCG the body is always able to obtain all the calories it needs from the abnormal fat deposits, regardless of whether it uses up 1500 or 4000 per day. It must be made very clear to you that you are living to a far greater extent on the fat which you are metabolizing than on what you eat.

HINT: Green tea and fiber are natural appetite suppressants.

__I have read the above and understand what this medical program is asking me to do and I am willing to do it 110%.

__I agree to follow the diet strictly and take the HCG twice daily. If I cheat I will document it. I WILL NOT SUBSTITUTE ANY OF FOODS NOT ON APPROVED LIST.

__I am not being coerced into doing this by anybody.

__I agree to commit to this program for a minimum of 6 weeks and take it seriously.

__I agree to weigh every day.

__I agree to come for follow-up every 3 weeks

__I agree to return every 3-4 weeks for follow-up and photos. The photographs, videos, and tapes shall be the property of Keri Sweeten, M.D., and may be used for teaching, publication or scientific research purposes. Your identity will not be revealed unless we expressly get your permission.

Patient Signature:_____

Witness:_____

Date:_____

Informed Consent

Sublingual HCG (Human Chorionic Gonadotropin) is a prescription medication used by Dr. Sweeten in her weight loss program.

With any drug there is the possibility of an allergic reaction or unusual reaction that may cause skin rash, difficulty breathing and other side effects, although rare.

HCG There may be some side effects to the HCG. The most commonly experienced are: tenderness of the breasts, disruption in menstrual cycles (i.e. early onset or delayed - usually one week) or breakthrough bleeding. It does not, however, interfere with the effectiveness of your contraception or birth control. Other possibilities not generally seen which may occur in male patients are tenderness in the groin.

Possible adverse reactions which may rarely occur include headache, irritability, restlessness, depression, fatigue, edema. Hypersensitivity is extremely rare. **Caution: If you are pregnant and/or will be nursing an infant DO NOT take this medication.**

HCG is virtually free of negative side effects, but because you must follow a very low calorie, low fat diet that can sometimes trigger a gallbladder attack in individuals who are genetically pre-disposed to gallbladder disease.

Your medication will be discontinued if there is an adverse reaction.

I understand that the program and medications may involve risk. I understand that there are no refunds, returns or store credit for medication and that there is no weight loss guarantee with our program. I have read and understand the information given to me about the medications. I have asked and had answered any questions that I may have after reading this form. I understand the possible side-effects and agree to advise KERISMA Centre for Medical Weight Loss if this should occur. I understand that I may quit the program at any time. I agree to stop the **HCG** if I become pregnant and agree to advise KERISMA Centre for Medical Weight Loss should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact KERISMA Centre for Medical Weight Loss. If I experience an emergency situation, I understand that I need to go to an emergency facility. I authorize KERISMA Centre for Medical Aesthetics to use my photos for advertising purposes as needed.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY UNDERSTANDING WOMEN OR KERISMA CENTRE FOR MEDICAL WEIGHT LOSS OF ANY CHANGE IN YOUR HEALTH STATUS.

_____ _____

Patient's Name (PLEASE PRINT) Patient's Signature

_____

Date

_____

Witness

MEDICATION ADVISORY FORM FOR APPETITE SUPPRESSANTS

The staff at UNDERSTANDING WOMEN and KERISMA Centre for Medical Weight Loss *hopes your experience with us will be pleasant as well as rewarding.* To ensure your experience with us is a pleasant, we want you to be aware there are several side effects and/or reactions to appetite suppressants. There is a possibility you may not experience any of these listed, however, the most typical or more commonly experienced side effects with using suppressants are:

dryness of mouth	unpleasant	occasional headaches
diarrhea and/or constipation	sleeplessness	

POSSIBLE SIDE EFFECTS

Appetite Suppressants: The medication may cause restlessness, dizziness, tremors, headaches, and/or depression. When taken as prescribed there are rarely any psychotic episodes. In some cases a patient may experience blood pressure elevation, rapid heartbeat and/or pounding in the chest. The less common, but possible risks are: primary pulmonary hypertension and valvular heart disease. Do not take if you have cardiopulmonary disease. These and other possible risks could be serious or fatal. Important; Doctors and Anesthesiologist require different lengths of time off different medications prior to surgery. We recommend that if you anticipate surgery in the near future do not go on this diet until you have recovered and been cleared by you surgeon. In order to avoid any possible delay in surgery, notify us before going off all medication from UNDERSTANDING WOMEN or KERISMA Centre for Medical Weight Loss at least two weeks before your surgical date.

How to Use This Medication: Follow the directions for using this medicine. This medication may be taken with food. Cautions; When taking this medicine alone or with other medicine(s) and/or alcohol, it may affect your ability to drive and/or operate equipment, or perform other potentially dangerous tasks. Until you are aware of how this medication affects your Central Nervous System, avoid activities that require alertness and/or good Psychomotor coordination. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE either prescription or over-the-counter, check with your Doctor or Pharmacist. If you are pregnant and/or will be nursing an infant DO NOT use this medication.

PLEASE DO NOT WAIT until your next visit to report these or any other side effects you may be experiencing to our nursing staff. Due to a wide variety of choices with selecting both the medication and strength, we can almost always help you become more comfortable.

I have carefully read and fully understand all the above information, and acknowledge the possibility of all risks with using the medications in this program. I therefore assume all risks, and hold Understanding Women, KERISMA Centre for Medical Weight Loss, and the provider(s), harmless to any, and/or all, reactions or side-effects experienced while taking any, and/or all, of said medications.

Each Patient will only be allowed one bottle (15 pills) of appetite suppressants per round of diet. The dosage is a half a pill per day. Refills will be not be given under any circumstances. **Int**._____

Patient's legal name_____Date_____

Witness_____Date_____

*The information contained in this advisory form is not intended to cover all possible uses, directions, precautions, drug interactions and/or adverse effects. This information is generalized and is not intended as specific medical advice.