Remember that the decisions you make today can help you prevent many of the health related problems you may develop starting tomorrow!

Our program is built upon the 3 elements of success. They are diet & nutrition, medication & supplements, and exercise & hydration.

If any one of the components is not followed or utilized the likelihood of success decreases.

THE 3 ELEMENTS OF SUCCESS

The efforts to overcome being overweight or obese are not always easy. That's why we outline the nutritional plan, supplements, and other important factors for your wellness success so that it is at least easy to follow. These components are the core of our weight loss program.

Weight loss is only one of the changes you can make to improve your health, wellness and overall quality of life. Your body composition has a huge impact on the stress that your body endures on a daily basis. Extra weight affects your heart, muscles, joints, and many other parts of your body and when you lose weight you will see and feel positive changes.

During your visit today with our new patient consultant and the physician, they are going to assess your risk factors and total wellness so that you will not only look and feel great once you reach your healthy weight, but you will also be much healthier than you are today.

You've taken a huge step today by coming to us. Now we ask that you follow the treatment plan developed by our trained staff so that together we can help you achieve your goals.

You can't afford to wait until tomorrow to start becoming healthier today!

Patient Information (Please Print)

FIRST NAME	LAST NAME	DATE

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	

EMERGENCY CONTACT (Last Name, First Name)	PHONE NUMBER

From time to time, we may wish to send you information or special offers that we may feel may be of interest to you regarding our weight loss program. We may also contact you in relation to consumer research, marketing and customer surveys.

PRIVACY: Your information will be kept strictly confidential and not provided to any third parties.

☐ **Yes, I would like to receive such information & offers by postal mail**
☐ **Yes, I would like to receive such information & offers by phone**
☐ **Yes, I would like to receive such information & offers by email**

How did you learn about the program?	
☐ Patient Referral	☐ Newspaper (Please Identify):
☐ Magazine (Please Identify):	☐ Television (Please Identify):
☐ Other (Please Describe):	☐ Internet

Weight History

NAME	DATE

Height:	Current Weight:	What is your desired weight:

How long have you been trying to lose?

What has been your heaviest weight?

When were you that weight? (record your age)

When did you first become overweight?

What do you think is the cause of your weight problem?

Have you ever stayed the same weight for ten (10) years or more? ☐ Yes ☐ No

Are any members of your household overweight? ☐ Yes ☐ No
If yes, please list relation and details...

What is your motivation for treatment in our weight loss & wellness program?
Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Reduce Pain
- ☐ Perform better
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller sizes
- ☐ Detoxify the body
- ☐ Look better
- ☐ Live longer
- ☐ Increase self confidence
- ☐ Lower blood pressure
- ☐ Look & feel younger
- ☐ Control blood sugar levels
- ☐ Reduce medications
- ☐ other (please describe):

In order to assist you in achieving your weight loss goal, please check the programs that you have previously participated in. Please list under comments if you were successful in obtaining your goal, and if not why the program did not meet your expectations.

Name of Program	Results?	Why this program fell short of your expectations...
☐ Weight Watchers		
☐ Jenny Craig		
☐ Slim Fast		
☐ Atkins		
☐ South Beach		
☐ L A Weight Loss		
☐ Nutri System		
☐ Lindora		
☐ Other		

Do you exercise? If so, how often do you exercise?

☐ Never ☐ Rarely ☐ Daily ☐ 4-5 times a week ☐ 2-3 times weekly ☐ once a week

What is your exercise routine?
Check all that apply.

☐ Walking
☐ Swimming
☐ Dancing
☐ Aerobics
☐ Pilates
☐ Stairmaster
☐ other (please describe):

☐ Bicycling
☐ Yoga
☐ Sports (basketball, tennis, etc.)
☐ Strength training
☐ Elliptical
☐ Treadmill / Jogging

Medical History

Patient Name:		Date:	

Family History (If blood relative has suffered the following, please indicate relationship.)			
Heart Attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

Have you ever been hospitalized? If yes, when and why?	
Year	**Illness or Operation**

Medications (Please list the medications you are currently taking, and as needed.)			
Medication	**Dosage**	**How Often**	**Reason**

Allergies (Please list any medications or food that you are allergic to.)

Medical History

Yes	No		Yes	No		Yes	No	
		Loss of hearing			Hemorrhoids			Anemia
		Ringing in ears			Hernia			Immune disorders
		Ear infections			Gall bladder			Alcohol abuse
		Bad vision			Sudden weight loss			Drug abuse
		Glaucoma			Liver disease			Hypertension
		Nose bleeds			Back pain			Heart disease
		Sinus trouble			Joint pain			Thyroid disease
		Sore throat			Broken bones			Cancer
		Allergies			Dizzy spells			Diabetes
		Hoarseness			Fainting spells			Stroke
		Pneumonia			Memory loss			Osteoporosis
		Bronchitis			Insomnia			GERD
		Asthma			Nervousness			Rashes
		Short of breath			Depression			Chicken pox
		Tuberculosis			Phobias			Mumps/measles
		Heart murmur			Manic depressive			Polio
		Palpitations			Anxiety			Are you pregnant?
		Irregular pulse			Schizophrenia			Could you be Pregnant?
		Swollen ankles			Bulimia			Are you breast feeding?
		Chest pain			Anorexia			Other:
		Loss of appetite			Other eating disorders			
		Indigestion			Frequent urination			
		Stomach ulcers			Kidney disease			
		Diarrhea			Prostate disease			
		Constipation			Headaches			
		Bloody/tarry stools			Fatigue			

Supplements (Please list the supplements you are currently taking, i.e. vitamins, fish oil, etc...)			
Supplement & Brand Name	**Dosage**	**How Often**	**Reason**

Wellness Goals

Which of the following supplements, or products, would you like to incorporate into your wellness Plan?
Check all that apply.

- ☐ Cardiovascular System
- ☐ Joints
- ☐ Bones
- ☐ Prostate
- ☐ Cognitive System (Mind)
- ☐ Weight Loss
- ☐ Beauty/Hair/Skin
- ☐ Immune System
- ☐ Depression
- ☐ Digestive System
- ☐ Sexual Activity
- ☐ Detoxifying the body
- ☐ Hair Loss
- ☐ Menopause
- ☐ Hormone Therapy
- ☐ Weight Maintenance
- ☐ Health Related Foods
- ☐ DNA Testing
- ☐ Anti-Aging
- ☐ Testosterone Levels
- ☐ other (please describe):

Do you feel like your health is improving or declining?

If you could take steps to improve your health for the long term, would you? ☐Yes ☐No

What is your #1 health concern?

What changes to your current health are the least important to you?

If you could change one thing today about your weight or wellness what would it be?

Do you have others in your family who have wellness concerns as well? ☐Yes ☐No
If yes, please list relation and details...

Appetite Suppressant and Weight Loss Consent

I hereby authorize Dr. Brinson and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise program, and lifestyle changes. I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. Appetite suppressants labeling suggestions are based on short-term studies of 12 weeks. The experience of Bariatric physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements and injections are effective for longer than 12 weeks.

Dr. Brinson and associates believe in the off label use of medications proven to be effective in medical studies to promote weight loss and in the use of nutritional supplements and injections. These injections, nutritional supplements and medications can help you lose weight faster and make you feel better while you are losing weight. These nutritional supplements, injections and medications can boost your energy, burn fat faster, and eliminate cravings. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise and or eat fewer calories. Dr. Brinson and associates disagree with this simplistic thinking, and believes that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting or an exchange-eating program without the use of the appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heart beat, and heart irregularities. Less common, but more serious risks are valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that there are risks associated with obesity. Among these risks are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, hips, knees, and feet. I also understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop significant gallbladder disease during their lifetime. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible.

There is no guarantee that the program will work for me. By consenting to treatment I agree to pay in full for all visits and charges at the time of each visit. **I understand that your services are not reimbursed by insurance, and that you do not provide or fill out claim forms for insurance purposes.** I understand that no refunds are

ever given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience; however, I may request that a prescription be written for the weekly dose of the medication.

I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Ashton C. Brinson, M.D. or this office's physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications.

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

My signature further confirms that I do not have a current history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. My signature also confirms that if I have a past history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, I have fully disclosed this information in my medial history, since these conditions constitute a contraindication to the use of appetite suppressants.

By signing below I certify that I have read and fully understand this consent form. **I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction.**

I further understand that Brinson Center for Health and Weight Loss and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

My signature below indicates my consent of treatment.

Patient: _____ Date: _____

Witness: _____

Physician Declaration

I have explained the contents of this document to the patient and have answered all the patient's 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 suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient had consented to therapy involving the appetite suppressants.

Physician's Signature: _____ Date: _____

Photographs Consent Form

I DO _____, DO NOT _____ (Please initial one) hereby authorize Brinson Center for Health and Weight Loss staff to take my fully clothed photograph during my initial consultation, during, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and are kept in my chart at all times.

I DO _____, DO NOT _____ (Please initial one) give permission for my photographs to be used by Brinson Center for Health and Weight Loss for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

Patient: _____ Date: _____

Witness: _____ Date: _____

For office use only

Receipt of Notice of Privacy Practices
Written Acknowledgement Form
&
Authorization for the use of Disclosure of Individually Identifiable Health Information to Business Associates of Ashton C. Brinson, M.D.

I, _____, have received a copy of

Patient Name

Dr. Brinson's Brinson Center for Health and Weight Loss's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

I hereby authorize the use or disclosure of my individually identifiable health information as described in the referenced Notice of Privacy Practice. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations (HIPAA) or State law. This authorization expires three (3) years from the date set forth below.

_____ _____

Signature of Patient Date

Patient authorization for disclosure of protected health information

I, _____, D.O.B. _____,

SS# _____, authorize Dr. Brinson and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name: _____

Name: _____

Name: _____

Name: _____

_____ _____
Signature Date

_____ _____
Witness Date