Georgia Medical Treatment Center

557 Riverstone Pkwy Ste. 140 Canton, Ga. 30114 770.345.2000-office 770.345.4524-fax
www.georgiamtc.com

Patient Information Form-Weight Loss

Patient Name: (Last)_____ (First)_____ (MI/Suffix)____

Date of Birth: _____Sex (circle one): Male Female Email Address:_____

Address: (Street Name) _____City:_____

State:_____ ZIP: _____ Home #: _____Cell #: _____

Current Physician Name/Number: _____ **(_____) _____-_____**

Emergency Contact:
Name: _____Relationship: _____Phone: _____

How did you hear about us (please use specific name if referred by another patient?

_____

Some services may be covered by your insurance carrier. Please provide your insurance information so that we may check your benefits:

Primary Health Insurance Name: _____
Member Policy Number: _____Group Number: _____
Policy Holder Name and DOB if other than self : _____

Secondary Health Insurance Name: _____
Member Policy Number: _____Group Number: _____
Policy Holder Name and DOB if other than self: _____

Financial Policy:

Thank you for selecting our practice for your health care needs. We are honored to be of service to you and/or 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.***

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, understand and agree to all of these statements.

_____ _____

Patient Signature Date

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CURRENT/PAST MEDICATIONS (within the last 12 months)

Name:	Dose:	Frequency:	Starting:	Ending:	Purpose:

SURGICAL PROCEDURES: (Hospital or In-office Procedures)

Date:	Procedure:	Purpose:

MAJOR ILLNESSES:

Name:	Start:	End:	Physician:	Treatment Notes:

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Please check if you're currently experiencing any of the following conditions currently or in the past 6 months:

□ Light Bothers Eyes	□ Sudden Weight Loss	□Nausea		
□ Back Pain/Stiffness	□Pins/Needles in Legs	□ Depression	□ Loss of Taste	□ Cold Feet
□ Arm/Hand Pain	□ Fatigue	□ Nervousness	□ Loss of Memory	□Chest Pain
□ Leg/Knee Pain	□ Sleeping Difficulties	□ Tension	□ Jaw Problems	□Fever
□ Loss of Smell	□ Cold Sweats	□Constipation	□ Fainting	
□ Dizziness	□ Allergies	□ Stomach Problems	□ Shortness of Breath	
□ Asthma	□ Blurred Vision	□ Night Pain	□ Bowel/Bladder Changes	
□ Pain between Shoulders	□ Numbing/Tingling in Arms/Hands		□ Ringing in Ears	
□ Neck Pain	□ Numbing/Tingling in the Legs/Feet			

□ Other: _____

***Medications helped:** Little Some Much
* **Exercise helped**: Little Some Much
***Nutrition helped**: Little Some Much

Is your weight interfering with you're: Work Sleep Daily Routine

Have you been treated by a physician for your weight? Yes No
If so, where and how long was treatment?_____

Are you under a doctor's care for any other reasons? If yes, explain: _____

Have you ever had a history of illegal substance or prescription abuse? _____**Yes** _____**No**

If yes, Please explain. _____

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Please check to indicate if you have ever had any of the following:

□ Aids/HIV	□ Cancer	□ Hepatitis	□Osteoporosis	□ Stroke
□ Alcoholism	□ Cataracts	□ Hernia	□ Pacemaker	□ Suicide Attempt
□ Allergy Shots	□ Substance Abuse	□ Herniated Disc	□ Thyroid Problems	□ Parkinson's Disease
□ Anemia	□ Chicken Pox	□ Herpes	□ Pinched Nerve	□ Tonsillitis
□ Anorexia	□ Diabetes	□ High Cholesterol	□ Pneumonia	□ Tuberculosis
□ Appendicitis	□ Emphysema	□ Kidney Disease	□ Polio	□ Tumors/Growths
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Prostate Problems	□ Typhoid Fever
□ Asthma	□ Fractures	□ Measles	□ Prosthesis	□ Ulcers
□ Bleeding Disorder s	□ Glaucoma	□ Migraines	□ Psychiatric Care	□ Vaginal Infections
□ Breast Lump	□ Goiter	□ Miscarriage	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bronchitis	□ Gonorrhea	□ Mononucleosis	□ Rheumatic Fever	□ Whooping Cough
□ Bulimia	□ Gout	□ Multiple Sclerosis	□ Scarlet Fever	□ Heart Disease
□ Mumps	□ High blood pressure	□ other: _____		

Please list any additional information we need to know to properly treat and/or diagnosis your medical condition:
_____

Please list any supplements that you are taking: _____
Is there a family history of any of the following? (Indicate family member; parents, grandparents, siblings, etc..)

□ Heart Disease _____ □ Diabetes _____

□ Cancer _____ □ Arthritis _____

What is your daily/weekly intake of the following?

Caffeine: _____cups/day Alcohol: _____drinks/week Cigarettes: _____packs/day

Please list any allergies you have: _____

Please tell us why you would like to lose weight? _____

Please tell us any other diets/programs/medications you've tried in the past to lose weight and when? _____

What is your current Height? _____Weight? _____

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Summary of Notice of Privacy Practices/HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information or PHI.
This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use ad disclosure of your protect health information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

Uses and Disclosure of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

By signing this form, I understand that:

- Protected Health Information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will the cease.
- The practice may condition receipt of treatment upon execution of this consent.

Uses and Disclosure not requiring your authorization: In the following circumstances, we may disclose your health information without your written authorization:

- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law

Patient Rights: As our patient you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is being used and disclosed.
- To request that we amend your health information
- To received notice of our privacy practices.
- **To obtain a copy of your Medical Records. We DO require 3 business days to furnish that request.**

If you have a question, concern, or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

_____ _____

Patient Signature Date

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Summary of Notice of Privacy Practices/HIPPA Patient Consent Form Continued

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family? (This includes PHI and/or scheduled appointments) If YES, please name the members allowed:	YES	NO

_____

_____

This consent was signed by: _____
(PRINT NAME CLEARLY)

Signature: _____ Date: _____

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Practice Rules and Regulations:

1. I agree to follow the dosing schedule and treatment recommendations prescribed to me by my doctor.
2. I will NEVER share, sell, or exchange my medications with anyone for any reason
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. **I know that this office does not replace LOST OR STOLEN prescriptions or controlled medications.**
4. I understand that I should not drive or operate heavy machinery while I am taking medications that my cause drowsiness or impaired cognitive function.
5. I agree to notify a staff member if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to the office for disposal.
6. I agree that if I receive controlled substance prescriptions from this office, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. The office phone triage hours are 9:00am to 4:00pm, Monday through Thursday and Friday 9:00am-12:30pm.
8. **I understand that abusive behavior or harassment toward any staff member WILL NOT be tolerated. Management will determine what actions can be considered harassment on a case-by-case basis and, if warned, I can be dismissed from the practice.**
9. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from the practice.
10. I know I am responsible for any payments on the DAY OF MY TREATMENT unless arrangements are made with management prior to my appointment.

By signing this agreement, you concur with all rules set in place, and that you have read in full, understood and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice. You accept these terms by signing below and this agreement is bond from the date below moving forward.

_____ _____

Print Name Clearly Signature of Patient or legal representative

Date: _____

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Consent to Treat

I,_____, authorize this practice and whomever they designate as their 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, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to 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 gain 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 treatments, ask your doctor now before signing this consent form.

I hereby authorize the Doctors at Georgia Medical Treatment Center or Back to Life Medical Group, LLC. to treat my case as they deem appropriate through the use of nutritional support, nutritional supplements, prescription medication and nutritional counseling.

Patient/Legal Guardian: _____ Date:_____

Witness: _____ Date:_____