Tucson Women's Center

www.tucsonwomenscenter.com

INTAKE FORM

Today's Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Apartment or Unit Number:_____ Zip Code:_____

City/State:_____ Home Telephone #:_____ Cellular:_____

Have you been to our office before? Yes / No **May we contact you at any of these numbers?** Yes / No

If No, How can we reach you?_____

E-Mail:_____

Date of Birth:_____ **Age:**_____ **Social Security #:**_____

Patient Status: Married (1): ___ Single (2): ___ Other (4): ___

Widowed (5):____ Separated (6): ___ Divorced (7): ___

Referred By: Yellow Pages_____ Internet_____ Friend_____ Dr._____ Former Patient____Other_____

Primary Care Physician:_____

Employment Status: Full Time (1):_____ Part Time (2):_____ Retired (3):_____ Unemployed (4):_____

Full Time Student (5):_____ Part Time Student (6):_____

Employer's Name:_____ Work Phone #:_____

Address:_____City/State/Zip Code:_____

Emergency Contact: Last Name:_____ First Name:_____

Relationship:_____ Address:_____ City:_____ State:_____

Zip Code:_____ Phone#:_____

* You will be charged for any services rendered to you today.

** There is a $25.00 medical record copy fee. Allow 2 weeks for copies of medical records. There is no charge to fax or mail medical records to other physician's.

*** There is a $25.00 charge for appointments not cancelled with a 24-hour notice AND if you are more than 15minutes late.

**** Tucson Women's Center makes no representations or warranties regarding the quality of services at any facility/provider we refer you to and do not guarantee successful treatment.

Signature:_____ **Date:**_____

TUCSON WOMEN'S CENTER

MEDICAL WEIGHT LOSS PROGRAM INTAKE

Name:_____

Date of Birth:_____

WEIGHT LOSS GOALS

1. What made you decide to make a change now?

2. Are there specific areas of your body that you would like to change?

3. Are you on a timeline (e.g. before the wedding, cruise, reunion)?

4. Do you have target values (e.g. goal weight, % body fat, BMI)?

WEIGHT HISTORY

5. Have you been over weight in the past?

	Yes	No
Child		
Adolescent		
Adult		

CURRENT DIET

6. What type of foods do you eat in an average day?

	Week day	Week end
Breakfast/snack		
Lunch/snack		
Dinner/ snack		

7. On a scale from 1-6 are you more likely to prepare your meals or eat out?

Eat in----------1----------2----------3----------4----------5---------6 Eat out

DIETING HISTORY

Type of diet	How long did you try it?	How much did you loose?	Why did you stop?

8. Do you have a history of eating disorders? Please describe.

9. Do you exercise? If so how often and for how long?

PAST MEDICAL HISTORY

i. Please check all that apply

	High blood pressure		Heart disease		Diabetes
	Thyroid disease		History of Asthma		Bleeding tendency
	Breast lump or tumor		Blood clots in legs		Epilepsy
	STI		Kidney infection		Bladder infection
	Migraine headaches		Rheumatic fever		Sickle cell anemia
	Mitral valve prolapse		Pelvic infection		Hepatitis

ii. Please check all that apply

☐ Depression ☐ Addiction (describe) ☐ Eating disorder (describe)

iii. List medications that you are currently taking

iv. List drug allergies and sensitivities

v. List previous surgeries

FAMILY HISTORY

	Hypertension	Heart disease	Diabetes	High cholesterol
Mother				
Father				
Siblings				

SOCIAL HISTORY

10. Do you have friends/family supporting you in your weight loss effort?

11. Do you smoke? Yes___ No___

12. Do you use any type of recreational drugs? Please list

13. How many alcohol containing drinks do you have per week?

Tucson Women's Center
Weight Loss Program Consent Form

I _____ authorize Dr. William Richardson, MD 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 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)

TUCSON WOMEN'S CENTER

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request.

I have read the above:

Patient's Signature	Date

Tucson Women's Center
Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Dr. William Richardson, MD to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

> "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.
>
> "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
>
> "As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. 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 program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness,

psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

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 I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

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, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO 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:**_____

PATIENT:_____**WITNESS:**_____
(or person with authority to consent for patient)

VI. 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 has consented to therapy involving the appetite suppressants in the manner indicated above.

_____
Physician's Signature

Tucson Women's Center
5240 East Knight Drive Suite # 112, Tucson, AZ 85712
PHONE: (520) 323-9682

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that contains a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and that I can request a copy of any revised notice to sent to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

_____Accepted _____Denied

Signature_____ Date:_____

MODEL NOTICE OF PRIVACY PRACTICES LANGUAGE

I. "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

A. Uses and disclosures.

1. Example of uses/disclosures
   a. Emergency Treatment
   b. Bill Collection
   c. Tucson Women's Center may contact the individual to provide appointment reminders or information about treatment plans.
2. If we receive a request for medical records from a legal representative, or if patient threatens legal action, we may provide PHI to our legal representative.
3. If a use or disclosure for any purpose described in paragraphs A1 or B of this section is prohibited or materially limited by other applicable law, the description of such use or disclosure will reflect the more stringent law as defined in § 160.202.
4. Other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization as provided by § 164.508(b)(5).

B. Individual rights. The notice must contain a statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, as follows:

1. The patient may request restrictions on certain uses and disclosures of protected health information as provided by § 164.522(a), TWC is not required to agree to a requested restriction;
2. The patient has the right to receive confidential communications of protected health information as provided by § 164.522(b), as applicable;
3. The patient has the right to inspect and copy protected health information as provided by § 164.524;
4. The patient has the right to amend protected health information as provided by § 164.526;
5. The patient has the right to receive an accounting of disclosures of protected health information as provided by § 164.528; and
6. Patient's who review the notice electronically may request a paper copy in accordance with § 164.520(C)(3).

C. TWC duties. The notice must contain:

1. TWC is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information;
2. TWC is required to abide by the terms of the notice currently in effect; and
3. In accordance with § 164.530(i)(2)(ii), TWC reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. Changes will be made to patients information packet.

D. Complaints. Individuals may complain to the TWC if they believe their privacy rights have been violated by contacting Dr. Richardson (Medical Director) or Elizabeth Ibarra (Office Manager). The patient will not be retaliated against for filing a complaint.

E. Effective date. This notice is in effect as of

F. Revisions to the notice. TWC must promptly revise and distribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in the notice. Except when required by law, a material change to any term of the notice will not be implemented prior to the effective date of the notice in which such material change is reflected.