PATIENT INFORMATION FORM

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

Name you prefer to be called:_____

Address:_____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____Cell phone Carrier_____

e-mail address: _____

Birthdate: _____ Gender (circle): M F

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Work phone: _____ Extension: _____

Social security number: _____ Driver License number: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, contact: _____

Relationship to patient: _____ Phone number: _____

Spouse's name: _____ Phone number: _____

FINANCIAL POLICY

Thank you for selecting Dr. Peramsetty 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 requirement 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 cash, Visa, Mastercard, Discover and American Express. I understand that Tuscaloosa Weight Loss will not issue refunds for products or services.

I agree that should this account be referred to a collection 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 of the above and agree to these statements.

_____ _____

Patient signature Date

PATIENT INFORMATION FORM

Name: _____ Birthdate: _____ Gender (circle): M F

1. Are you in good health at the present time, to the best of your knowledge? Yes No

   If no, please explain:

   _____

   _____

2. Are you currently under a doctor's care? Yes No

3. Are you currently taking any medications? Yes No

   If yes, please list below:

   Prescription Drugs *(list all)*

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Over-the-counter medications, including vitamins & supplements

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

   Name: _____ Dosage: _____

4. Any allergies to medications? Yes No

   If yes, please list all:

   _____

   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No

At what age? _____

7. History of heart attack, chest pains or other heart condition? Yes No

8. History of swelling feet? Yes No

9. History of frequent headaches or migraines? Yes No

If yes, list medications taken for headaches _____

10. History of constipation (difficulty with bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. History of sleep apnea? Yes No

13. Gynecologic History

Have you ever been pregnant? Yes No

If yes, please list number, dates and delivery method (natural or C-section):

_____

_____

Menstrual onset: _____ Duration: _____ Regular (yes or no)? _____

Pain associated? _____ Last menstrual period? _____

Hormone replacement therapy? _____ Birth Control Pills? _____

Date of last check-up: _____

14. History of serious injuries? Yes No

If yes, please list all and specify dates:

_____

15. History of surgeries? Yes No

If yes, please list all and specify dates:

_____

16. Family History

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

17. Has any blood relative ever had any of the following?

Glaucoma	Yes	No	Who? _____
Asthma	Yes	No	Who? _____
Epilepsy	Yes	No	Who? _____
High Blood Pressure	Yes	No	Who? _____
Kidney Disease	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Psychiatric Disorder	Yes	No	Who? _____
Heart disease	Yes	No	Who? _____
Stroke	Yes	No	Who? _____

18. Do you have a history of any of the following? *(check all that apply)*

_____	Polio	_____	Measles	_____	Tonsillitis
_____	Jaundice	_____	Mumps	_____	Pleurisy
_____	Kidney disease	_____	Scarlet fever	_____	Liver disease
_____	Lung disease	_____	Whooping cough	_____	Chicken pox
_____	Rheumatic fever	_____	Bleeding disorder	_____	Nervous breakdown
_____	Ulcers	_____	Gout	_____	Thyroid disease
_____	Anemia	_____	Heart valve disorder	_____	Heart disease
_____	Tuberculosis	_____	Gallbladder disorder	_____	Psychiatric illness
_____	Drug abuse	_____	Eating disorder	_____	Alcohol abuse
_____	Pneumonia	_____	Malaria	_____	Typhoid fever
_____	Cholera	_____	Cancer	_____	Blood transfusion
_____	Arthritis	_____	Osteoporosis	_____	Other: _____

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives

1. I, _____ *(patient or patient guardian)* authorize Dr. Peramsetty to assist me in my weight reduction efforts. I understand that my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks 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

WEIGHT LOSS PROGRAM CONSENT FORM

I _____ *(patient or patient guardian)* authorize Dr. Peramsetty 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:**_____

PATIENT:_____ **WITNESS:**_____

(or person with authority to consent for patient)

$25 NO SHOW CHARGE

Due to the large number of missed appointments, we have implemented a charge for all no-show appointments, as well as all appointments cancelled without 24 hour notice.

When you are scheduled for an appointment, that time is blocked out for you only; therefore, we expect that you notify us in advance, should you find that you will not be able to keep said appointment.

We will begin charging the fee of $25 effective July 1, 2011.

I, the undersigned, do hereby state that I have read the above, and am aware that I will incur a $25 charge should I miss my appointment, or fail to allow 24 hour notice of cancellation.

_____

Print patient name

_____

Patient signature

_____ _____

Date Chart Number