RIGHT WEIGH
Medical Clinic
601.936.2887 • www.rightweighclinic.com

For Office Use Only
____ HF
____LabCorp
____NPL
____ Login
____ TW
____iC

The patient information below is required for the dispensing of medication.

First: _____

Middle: _____

Last: _____

SSN: _____

Dr. License: _____ State: _____

Email: _____

Physical Address: _____

Apt./Ste. _____

City:_____ State: _____ Zip: _____

DOB: _____ Gender: _____

Home Phone:_____

Cell Phone: _____

*Please list your Mailing Address **if different from mailing address:***

Address:_____

City: _____

State:_____ Zip: _____

I heard about *Right Weigh*:

- ☐ Commercial
- ☐ Online Advertisement
- ☐ Online Search
- ☐ Newspaper/Magazine Ad
- ☐ Referred by a Friend:_____
- ☐ Referred by Doctor/Clinic/Other:_____
- ☐ Drive by/Saw from Street
- ☐ Special Event:_____

☐ I would like to receive *Special Promotions and Updated Doctor Availability* via ***Right Weigh Text Alerts.***

All patient records are kept private in accordance with strict industry guidelines.

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Patient Information

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

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

Birthdate: _____Age: _____Sex: M F Height: __'___"

Patient Employer: _____ Occupation: _____

Work phone No: _____Email Address: _____

How did you hear about us? _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

NUTRITION HISTORY

Do you frequently skip meals? Yes _____ No _____
If yes, which ones? Breakfast _____ Lunch _____ Dinner _____
Who plans meals? _____ Cooks? _____ Food shops? _____
How many times per week do you eat in a restaurant? 0-2_____ 3-5_____ 6 or more_____
How many times per week do you eat fast foods? 0-2_____ 3-5 _____ 6 or more _____
How often are the following meals eaten out? Breakfast _____ Lunch _____ Dinner_____
How often do you snack between meals? _____
What are the foods you crave the most? _____
What are your worst food habits? _____

EMOTIONAL/BEHAVIORAL ISSUES

Are your physical activities restricted for any medical reasons?
_____
If yes, list reasons:
_____

Are you currently getting any exercise? Yes / No
If you do get exercise, what? _____

Have you ever diagnosed with an eating disorder? _____ If yes, when? _____
Where? _____
Treatment_____
What feelings or situations trigger you to eat even though you are not hungry?

____ Anger	____Celebrations	____Loneliness
____Anxiety/ nervousness	____ Depression	____Stress
____Boredom	____ Family gatherings	____ Social situations

Do you struggle with binge eating? Frequently _____ Occasionally _____ Rarely _____

Are there any personal problems/ situations you have experienced or anticipate experiencing (i.e. relationships, job changes) that may affect your weight loss efforts? Yes _____No _____ if yes, explain
_____

Have you ever been treated for a psychiatric diagnosis, including drug or alcohol addiction? Yes _____ No _____ If yes, what was the diagnosis?

_____

What was the treatment? _____

Were you overweight as a child? Yes_____No _____

Are any of the following family members overweight? Spouse_____ Mother_____ Father_____

What is your goal weight (i.e. realistic, healthy weight)? _____

Which of the following weight loss programs have you tried?

__Diet Center __Weight Watchers __Nutri-system __Jenny Craig __Own program __R.D. Counseling __Liquid Diet__ Overeaters Anonymous __ Physician Program __ Other If other, please describe_____

How motivated are you to lose weight? __Extremely __Moderately __Somewhat __A little

How committed are you to making lifestyle changes? __Extremely __Moderately __Somewhat __A little

Social History

Do you drink any alcohol?_____If so, how often?_____

Do you smoke?_____ If so, how often and how much_____

Symptoms

Are you experiencing any of the following? Check all that apply:

__ Glaucoma	__Nausea	__Seizures/ convulsions
__Abdominal pain	__Vomiting	__Numbness or tingling
__Heart Disease	__Diarrhea	__Fainting
__Chest pain	__Constipation	__Heat & cold intolerance
__Irregular heart beat	__Jaundice	__Excessive thirst
__Swelling of ankles/feet	__Polycystic ovary disease	__Sudden weight gain/loss
__Circulation deficiency	__ Pain/swelling in joints	__Frequent Urination
__Fainting	__Back/neck pain	__Increased appetite
__Shortness of Breath	__Rashes	__Anemia
__Wheezing	__Dizziness	__Weak with minimal exercise
__Indigestion	__Severe Headaches	__Tender swollen lymph nodes

Are you or can you possibly be pregnant right now? _____

FAMILY HISTORY

It is important that we understand any issues that may be hereditary. Please include if there is a history of diabetes, high blood pressure, high cholesterol, cancer, coronary heart disease, congestive heart failure, thyroid issues, obesity, or any other issues among relatives in your family to the best of your knowledge.

Relative	State of Health/Medical Problems/Cause of Death	Deceased? Yes/No	If Deceased, Age at time of death
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Spouse			

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Medical History

Who is your Physician?

_____

Who are your Specialists? _____

Do you have any of the following illnesses?

__GLAUCOMA
__SLEEP APNEA
__HEART DISEASE
__Heart Rhythm Problems
__ASTHMA
__COPD/Emphysema
__Smoking addiction
__GERD
__Crohn's Disease
__Colitis
__Stomach
__Ulcers
__Obesity
__Gall Stones
__Hypertension
__P.C.O.S (polycystic ovary syndrome)
__Kidney Failure
__Kidney Stones
__Gout
__ARTHRITIS
__Lupus
__Fibromyalgia
__Scoliosis
__PSORIASIS
__STROKES
__Headaches
__Migraines
__Neuropathy
__ADDICTION TO ALCOHOL
__Addiction to any other drug
__Eating disorder
__Anorexia/ Bulimia
__Bipolar Disorder
__Depression
__Anxiety
__DIABETES
__Hyperthyroidism
__Hypothyroidism
__Hyperlipidemia
__Hypercholesterolemia
__ANEMIA
__Cancer

SURGICAL HISTORY

Have you had any Surgeries?

If yes, which one, when was the operation performed and the name of the Physician who performed the procedure?

Year	Operation	Physician
_____	_____	_____
_____	_____	_____

Do you have any drug or food allergies? _____If so what kind?_____

Please List All medication you are taking at this present time. (Including nonprescription) Vitamins etc.

Medication	Dosage	How Often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
11.		
12.		

Signature: _____ (Patient)

Signature:_____(Physician)

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Weight Loss Program Consent Form

I _____ authorize **Dr. Lawrence Hubacek, MD** and whomever he may designate 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 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 certify that I am not receiving any appetite suppressant stimulant such as Phentermine or any ADD medications from another weight loss clinic, physician, or pharmacy and will not do so while I am a patient of Right Weigh Clinic without first informing Right Weigh Staff and Dr. Jeff Hubacek.

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: _____

Patient: _____
(Or person with authority to consent for patient)

Notice of Privacy

Our Notice of Privacy Practices provides information about how we may use disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgment. As provided in our Notice, The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from the Privacy/Security Officer, Right Weigh Clinic LLC. 309B Airport Road, Pearl, MS, 39208 or at our website www.rightweighclinic.com

By signing this form, you acknowledge that you have been provided a copy of our Notice of Privacy Practices.

_____ _____

Patient Signature Date

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Dr. Hubacek,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 period 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. **I will notify the physician if I am taking any anti-depressant medications.**

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. 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.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY OTHER QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGHNING THIS CONSENT FORM.

DATE: _____

PATIENT: _____

(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

Financial Policy:

Thank you for selecting Dr. Hubacek,MD 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 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. For your convenience, we accept Visa, MasterCard and checks. 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 all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

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Patient Injection Agreement

☐ *I understand that the lipotropic injections are vitamins and amino acids and supplements to compliment a calorie-restricted diet. They aid in removing fat from the liver and body fat ARE NOT WEIGHT LOSS INJECTIONS themselves. The injections are only to be used in conjunction with a comprehensive weight loss program that includes menu and exercise.*

*Signature*_____

*Date*_____

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Release of Medical Records/Medical Records Request Form

Please fax the most recent bloodwork results on file for:

Patient:_____

I give permission for my medical records (blood work, chart, EKG) to be released to Right Weigh Clinic

Printed Name _____DOB: _____

Signature _____

Date _____

Physician/Nurse Practitioner:_____

Clinic/Physician Office:_____

Phone:_____ Fax:_____

Date of most recent lab work:_____

Please Fax most recent Lab Results that include Lipid Panel, CBC, Glucose and/or A1C to:

Right Weigh Clinic

Dr. Lawrence "Jeff" Hubacek

309B Airport Rd.

Pearl MS, 39208

Phone: 662-832-0299

Fax: 855-866-6287

List of Known Allergies :

_____ **Penicillin**

_____ **Sulfa Drug**

_____ **Other** _____

_____

_____

_____ **No Known Drug Allergies**

_____

Signature

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For Office Use Only

Name: _____

☐ Warm Up ☐ Exercise Prg 2wks

☐ Cool Down ☐ Stretches

☐ Follow Up ☐ Progression

Date:_____/_____/_____

Personalized Right Weigh Workout

Right Weigh Clinic is excited to offer personalized exercise regimens to our patients upon request. Our knowledgeable and friendly staff is happy to assist you with customizing an exercise plan that works for you. In order to provide the best service and make the most of your exercise regimen, please answer the following questions.

The following questions have been developed in order to provide you with a meaningful workout as well as a way to determine the difficulty and consistency of your workouts.

Yes	No	
☐	☐	Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
☐	☐	Do you feel pain in your chest when you do physical activity?
☐	☐	In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	Do you have a bone or joint problem (for example: back, knee, or hip) that could be made worse by a change in your physical activity?
☐	☐	Is your doctor currently prescribing drugs (for example: water pills) for your blood pressure or heart condition?
☐	☐	Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more of the questions:

- Talk with your doctor by phone or in person BEFORE you start becoming more physically active.
- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or you may need to restrict your activities to those which are safe for you.

If you answered NO to ALL of the questions, you can reasonably be sure that you can:

- Start becoming more physically active – begin slowly and build up gradually, as this is the safest and easiest way
- Tell us what physical limitations you may have below:
  - — Bad Knees
  - — Arthritis
  - — Carpel Tunnel
  - — Knee Replacements
  - — Gout
  - — Neuropathy
  - — Other _____
  - — Have you previously had any broken bones or other serious injury? Please Specify:

    _____
- Tell us how much time do you have daily to devote to exercise: _____
- What workout equipment, if any, do you have access to:_____
- Are you currently exercising? _____ If so, what workouts, how often and how long do the workouts last?

  _____

If you are interested in receiving a personalized workout sent directly to your phone or email including descriptions with recommended reps and times, please list your mobile number and email address.

Patient Name:_____ Age:_____

Mobile Number: _____-_____-_____ Email Address: _____@_____

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Want to Save 20%?

Ask about our 6 Month Membership Savings Package!

Receive 20% Off the Following as Part of our Package:

✓Monthly Doctor Visits
✓Monthly Prescriptions
✓Weekly Weigh-Ins
✓Weekly Lipoplex Injections

- **Our Patients who take advantage of our 6 month program usually lose more weight faster than patients who come less often.**
- **By coming in each week, Patients can receive more detailed dieting and exercise guidance from our friendly and knowledgeable staff.**
- ***Always in a hurry?*** **We offer easy, worry-free automatic monthly billing so you can get in and out quickly.**

Ask our Staff about the Membership Package at Checkout to start saving on your weight loss journey!