For Office Use Only
Pearl *REZ*

___/___/____

PMP____
____ HF ____LabCorp
____NPL ____ ClubTxt
____iCon ___Chart Photo

RIGHT WEIGH Medical Clinic

1. ***Please Fill Out This Top Sheet (Page 1), return it to the Front Desk, and present your photo ID (Driver's License).***
2. For identification purposes in charts, we take a photo of our patients' face.
3. Once you have returned this sheet, please complete the Remaining Forms.

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

First: _____

Middle: _____

Last: _____

SSN: _____

Drv. License: _____ State: _____

Email: _____

Physical Address: _____

Apt./Ste. _____

City:_____ State: _____ Zip: _____

DOB: _____ Gender: _____

Home Phone:_____

Cell Phone: _____

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

Address:_____

City: _____

State:_____ Zip: _____

Please Circle One:

Do You have a Pacemaker/Electrical/Metal Implant? YES NO

If yes, please Specify: _____

Are you Interested in a Prescription Appetite Suppressant? YES NO Unsure

I heard about *Right Weigh*:

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

RIGHT WEIGH Medical Clinic

General Patient Information:

Patient First Name: _____ MI:_____ Last: _____

Physical Address: _____

City: _____ State: _____Zip: _____

Birthdate: _____ Age: _____ Gender: _____ Height: ____' _____"

Phone: _____ Email: _____

Patient Employer: _____ Occupation: _____

Mailing Address (*if different from physical address*): _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Name _____ Relationship: _____

Phone: _____

Right Weigh Clinic follows strict industry guidelines to protect the privacy of our patients. Please be as descriptive as necessary so we may better serve you

Please complete the following questions to the best of your knowledge.

Have you ever tried a weight loss program before? YES NO

If so, what program(s) have you tried? _____

How would you rate your understanding of food nutrition? (i.e. Protein, Carbohydrates, Calories, reading a food label, etc.)

I don't know Basic Understanding Proficient

While we provide an overview of our program on your first visit, please select any topic you feel you may need extra help with. *Select all that apply:* _____ None

___ Nutrition Basics ___ Reading a Food Label ___ Recording Meals ___ Exercise Plans

___ Step by step meal plans to follow ___ Medication Information ___ Vitamin Supplements

___ Diabetes Management ___ Insulin Resistance ___ Other: _____

What is your goal weight? _____

What foods do you crave the most? _____

What are your worst food/beverage habits? _____

Circle how many meals per week do you eat outside the home: None 1-2/wk 2-3/wk 3-4/wk 4-5/wk more than 5/wk

Do you snack between meals: Yes No

Do you plan your meals: Yes No

Who is responsible for preparing meals at your home? Myself Spouse Parent Other:_____

Are you currently getting any physical exercise? Yes No

If Yes, please list including frequency: _____

Are your physical activities limited for any medical reason? Yes No

If Yes, please explain: _____

Do you have any dietary restrictions? [ ] No Food Restrictions [ ] Vegetarian [ ] Vegan [ ] Pescatarian

If Other, please explain: _____

Select any feelings or situations that trigger you to eat even though you are not hungry:

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

Have you ever been diagnosed with an eating problem? Yes No

If yes, what diagnosis? _____

Are there any personal problems/ situations you have experienced or anticipate experiencing (i.e. relationships, job changes, loss of family member) that may have affected or will affect your weight loss efforts? Yes No

If yes, please explain:

_____

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

_____

If yes, what was the treatment? _____

Were you overweight as a child? Yes No
Are you CURRENTLY experiencing any of the following? Check all that apply:

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

Are you or can you possibly be pregnant right now? YES NO

Please select or list all known drug and food allergies:

___ *I Have No Known Drug or Food Allergies* ___ Penicillin ____ Sulfa Drug

_____ _____ _____

_____ _____ _____

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

Medications	Dosage	How Often?
[ ] *Not currently taking any medications*	-	-
1.		
2.		
3.		
4.		
5.		

Signature: _____ **(Patient)** **Signature:**_____**(Physician)**

RIGHT WEIGH Medical Clinic

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. If you are unsure, write "UNKNOWN"

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			

MEDICAL HISTORY

Primary Care Physician: _____ Clinic Name: _____

Specialists who treat you: 1. _____Clinic Name: _____

2. _____Clinic Name:_____

3._____Clinic Name:_____

Throughout Your Medical History, Have you EVER been diagnosed with 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 drug
__Eating disorder
__Anorexia/ Bulimia
__Bipolar Disorder
__Depression
__Anxiety
__DIABETES
__Hyperthyroidism
__Hypothyroidism
__Hyperlipidemia
__Hypercholesterolemia
__ANEMIA
__Cancer

Other: _____

Have you ever given birth to a baby over 9lbs? Yes No

Have you ever been diagnosed with Gestational Diabetes? Yes No

Has any of your immediate family members i.e. Mother, Father, Brother, Sister ever been diagnosed with diabetes?

Yes No

SOCIAL HISTORY

Alcohol Use: None Heavy Light Social Occasional

If so, Circle all that you drink: Beer Wine Liquor

Smoking: Never Smoked Current Smoker Some Days Current Smoker Everyday Former Smoker

If Current or Former, Circle all that you use/used: Cigarettes Cigars

SURGICAL HISTORY

Please list any surgeries or operations you've had along with the year and physician who performed the procedure:

Year	**Operation**	**Physician**
_____	_____	_____
_____	_____	_____
_____	_____	_____

___ No Surgeries

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

Weight Loss Program Consent

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)

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

VII. 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

COVID-19 Pandemic Treatment Consent Form

I knowingly and willingly consent to treatment for weight control during the COVID-19 pandemic. Treatments include physician exams, body mass analyses, vital signs such as blood pressure, EKG, body measurements, and other services that will require physical contact.

I understand that COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine every person who may be positive for COVID-19, given the limits in virus testing. It could potentially be transmitted through particles in the air or by contact.

I confirm that I am not presenting any of the following symptoms of COVID-19 such as those listed below:

- Fever
- Shortness of Breath
- Loss of sense of taste or smell
- Dry or wet cough
- Runny Nose
- Sore Throat

I confirm that I will notify Right Weigh Clinic staff if I have:

- Been diagnosed with COVID-19
- Been in close contact with anyone diagnosed with COVID-19
- Travelled Commercially in the last two weeks

Right Weigh Clinic practices all reasonable forms of Personal Protective Equipment including face masks, face shields, social distancing, and disinfecting all equipment and other surfaces between patients.

I agree to hold Right Weigh Clinic, LLC and Reservoir Right Weigh Clinic, LLC harmless should I become infected with COVID-19 at any point. I agree to refrain from any litigation concerning a COVID-19 infection against Right Weigh Clinic, LLC, Reservoir Right Weigh Clinic, LLC, it's employees or any entities associated.

PLEASE WEAR A FACE MASK IF YOU HAVE ONE AVAILBLE.

Print Name :_____

Sign Name: _____ Date: _____