Spokane Wellness Center

WELCOME TO OUR PRACTICE

Please answer the following questions so we can better assist your healthcare needs.

PATIENT INFORMATION

Date_____ Soc. Sec. # _____ Birth Date _____

Name _____
(Last Name) (First Name) (Initial) (Maiden Name)

Address_____ Home Phone (____) _____

City_____ State _____ Zip Code _____

Please Circle Sex: M / F Status: Minor / Single / Married / Divorced / Widowed / Separated

Employer_____Occupation _____

E-Mail Address _____

Emergency contact: _____ Phone (____) _____

Please list your present health concerns, problems, or symptoms:

_____

DIETING HISTORY: How have you attempted to lose weight in the past? (exercise, diet, medications, behavioral therapy, etc)

☐ Exercise ☐ Diet ☐ Medications ☐ Behavioral therapy ☐ Jenny Craig ☐ Wt Watchers

☐ NutriSystem ☐ Atkins Diet ☐ 17 Day Diet ☐ South Beach Diet ☐ Mediterranean Diet
☐ Other: _____

What were your outcomes with past weight loss attempts ? _____

_____

Your goal weight: _____ lbs. Age when you were last at your goal weight: _____
What weight loss methods have been successful for you in the past? _____
What is the most you have weighed and what year was this? _____
What is the least you have weighed and what year was this? _____
How many days per week do you get moderate exercise? (heart pounding, breathing heavy)____
What type(s) of exercise are you currently doing? _____
How compliant have you been with previous weight loss programs? _____
What were the barriers you faced in being compliant (time, motivation, etc.) _____

CURRENT EATING HABITS:

What are your current eating habits (low/high calorie, low/high fat, low/high carbohydrate, mostly fast food, fried foods, vegetarian, vegan etc.)? ____ How many times per day do you eat? _____ Do you eat multiple small meals or a couple large meals each day? _____ Do you currently monitor your macronutrient intake (such as carbohydrates/fats/proteins)? _____

_____

Which of the following are your challenges? ☐ Portion size ☐ Too many carbs ☐ Too few proteins

☐ Skipping meals ☐ Eating out ☐ Alcohol consumption ☐ Fried foods

Are you an emotional or stress eater (if so, what prompts you to eat?) _____

_____

How many ounces of each of the following are consumed each day? (8 oz = 1 cup) Water ____ oz Juice ____ oz Milk ____ oz Soda ____ oz Diet Soda ____ oz Sports Drink ____ oz Unsweetened Tea ____ oz Coffee ____ oz Decaffeinated drinks ____ oz Other-Type_____ ____ oz, Type _____ ____ oz

LIFESTYLE:

How much television do you watch per day (hours/Minutes)? _____

If you consume alcohol, how much do you consume daily/weekly/monthly? _____

How often do you consume alcohol?_____x's/wk;_____x's/month;_____x's/year

Do you smoke? YES NO How much per day?_____Age you started smoking_____

If you use to smoke, when did you quit? _____

Do you use cocaine, marijuana or other drugs? ☐ YES ☐ NO If YES, what?_____

If you use to use cocaine, marijuana or other drugs, when did you quit? _____

How many hours of sleep do you get nightly on average? _____

Do you consider your life, job, etc. to be stressful? _____

If so, how stressful on a scale of 1-10 (1 minimal, 10 severe) would you say your life is? _____

Which of the following seem to sabotage your weight loss efforts?

☐ Lack of time for planning/self ☐ Eating late/waking up eating ☐ Eating too fast ☐ Always hungry

☐ Stress/comfort eating ☐ Enjoyment of food ☐ Liquid calories (alcohol) ☐ Specific cravings

☐ Boredom eating ☐ Social event ☐ Mindless eating/habit ☐ Other: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
		0	1	2	3
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
Feeling tired or having little energy					
Poor appetite or overeating					
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down					
Trouble concentrating on things such as reading the newspaper or watching television					
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual					
Thinking that you would be better off dead or that you want to hurt yourself in some way					
Totals					

If you checked off any problem on the above chart, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Are you ready for lifestyle changes to be a part of your weight control program? ☐ YES ☐ NO If yes, rate on a scale of 1-10 (1 being a little ready, 10 being extremely ready) _____

Are you willing to keep a food journal, log nutrition on-line or use a smart phone application? ☐ YES ☐ NO

Which of the following do you think would help you on your weight loss journey?

☐ Learning how to eat "real food" and making my own healthy choices

☐ Food delivered right to my door to just eat that

☐ A program with mainly protein shakes/bars and one sensible dinner

☐ What I really need is:

_____

MEDICAL HISTORY

When was your last physical exam? _____

Provider's Name: _____ Phone ( ) _____

1. Are you currently under medical treatment ☐ YES ☐ NO
2. Are you currently under medical treatment? ☐ YES ☐ NO
   Please describe: _____
   _____
3. Have you ever had any serious illness or operations? ☐ YES ☐ NO
   Please describe: _____
   _____
4. Are you currently taking any medications? ☐ YES ☐ NO
   Please **list all medications** (prescribed and over-the-counter):
   _____
   _____
   _____
5. Are you currently taking any supplements, vitamins, herbs, etc.? ☐ YES ☐ NO
   Please list all: _____
   _____
6. Have you had any allergic reactions to Penicillin, Sulfa or any other medications? If yes, what medications: _____
7. Do you any food allergies or sensitivities? _____
   _____
   _____
8. Do you have a history of eating disorders (anorexia, bulimia, binge eating, etc.)?
   Explain: _____
   _____

9. Do you have a history of depression, paranoia, psychosis or chemical dependence? ☐ YES ☐ NO
   If yes, what do you have a history of? _____
   Has your condition been treated? ☐ YES ☐ NO How was your condition treated/what with? _____
   _____

FAMILY HISTORY (this includes mother, father, sister, brother, aunts/uncles, cousins, grandparents)
Does anyone in your family have any of the following:

- Heart disease/heart attack/congestive heart failure _____
- Cancer (type) _____
- High cholesterol _____
- High blood pressure _____
- Hypothyroidism _____
- Sudden death <40 from medical condition _____
- Diabetes or borderline _____
- Stroke _____
- Mental illness (bipolar, depression, etc.) _____
- Drug/alcohol/medication abuse _____
- Who in the family struggles with weight? _____
- Other family medical conditions _____

Spokane Wellness Center

ALL FEMALE PATIENTS SHOULD READ AND SIGN THIS PAGE

WOMEN ONLY –

Do you have regular periods? ☐ YES ☐ NO

Have you ever been pregnant? ☐ YES ☐ NO

Number of pregnancies _____

Please circle one:

Have you ever had a tubal ligation, (tying of tubes) ablation, or hysterectomy? ☐ YES ☐ NO

Do you currently have an IUD or take birth control pills? ☐ YES ☐ NO

Have you been pregnant in the past 12 months? ☐ YES ☐ NO

If you answered yes, when did you deliver? _____

Vaginal/C-section delivery? _____

Have you had your post-partum follow-up visit with your OB yet? ☐ YES ☐ NO

Are you currently breastfeeding? ☐ YES ☐ NO

PLEASE NOTE:

The medical providers and staff of Spokane Wellness Center recommend and strongly encourage the consistent use of contraception to avoid pregnancy during treatment with our medications for ALL females of childbearing age. This is due to the increased risk of teratogenicity (fetal harm/damage) with the use of our medications.

By signing below, I am stating that I have read this document and understand the importance of using contraceptive methods while taking these medications. I understand if I should become pregnant, I should discontinue the use of these medications immediately and report my pregnancy to Spokane Wellness Center and its health care providers.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

_____ _____

Witness Signature Date

Review of Systems

PLEASE INDIVIDUALLY CHECK EACH CONDITION YOU CURRENTLY HAVE

Name: _____ **Date of Birth:** _____

Constitutional
- ☐ High Blood Pressure
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Headaches/migraines

Ears/nose/mouth/throat
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Problems with thyroid
- ☐ Sinus Trouble

Neurological
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Seizures/Epilepsy
- ☐ Stroke

Skin
- ☐ Rashes
- ☐ Lesions
- ☐ Ulcers
- ☐ Jaundice

Endocrine
- ☐ Thyroid issues
- ☐ Diabetes

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Emphysema/COPD
- ☐ Asthma

Gastrointestinal
- ☐ Constipation
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Heartburn/acid reflux
- ☐ Irritable bowel syndrome
- ☐ Hepatitis Type _____

Musculoskeletal
- ☐ Joint pain/stiffness
- ☐ Muscle pain/weakness
- ☐ Back pain/problems
- ☐ Arthritis
- ☐ Carpal tunnel syndrome
- ☐ Fibromyalgia
- ☐ Gout

Cardiovascular
- ☐ Chest pain/angina
- ☐ Palpitations
- ☐ Murmur
- ☐ Swelling of feet/ankles
- ☐ Congenital Heart lesion
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Cholesterol

Other
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Chronic fatigue syndrome
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Eyes
- ☐ Glaucoma
- ☐ Eye glasses/contacts
- ☐ Blurred/double vision

Genitourinary
- ☐ Problems with urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate enlargement
- ☐ Polycystic Ovarian Disease (PCOS/PCOD)

Hematologic/lymphatic
- ☐ Bleeding/bruising tendency
- ☐ Blood clots
- ☐ Cancer
- ☐ Anemia (low blood count)
- ☐ Blood Disease

Psychological
- ☐ Bipolar
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric care
- ☐ Stress

Please list any psychiatric history including diagnoses & treatments: _____

_____

_____

Please list & describe any other medical conditions not listed above: _____

_____

_____

Past Surgical History

PLEASE INDIVIDUALLY CHECK EACH SURGICAL PROCEDURE YOU HAVE HAD IN THE PAST

Name: _____ **Date of Birth:** _____

Cardiac Surgery
- ☐ Pacemaker
- ☐ Bypass
- ☐ Stents

Gastrointestinal Surgery
- ☐ Gallbladder
- ☐ Gastric bypass Date:_____Weight Loss:_____Able to maintain? ☐ YES ☐ NO
- ☐ Lap-band Date:_____Weight Loss:_____Able to maintain? ☐ YES ☐ NO
- ☐ Hernia repair

Orthopedic Surgery
- ☐ Joint replacement
- ☐ Arthroscopic (Scope)
- ☐ Spinal fusion/discectomy/laminectomy

Gynecological Surgery
- ☐ Hysterectomy
  - ☐ With ovaries removed
  - ☐ W/out ovaries removed
- ☐ Tubal ligation
- ☐ Caesarean Section
- ☐ Ablation

Genitourinary Surgery
- ☐ Kidney Stents (kidney stones)
- ☐ Vasectomy
- ☐ Laser (for stones)

Please list any other surgical procedures you have had not listed above: _____

_____

_____

_____

_____ _____

Patient Signature Date

To be completed by Office Staff:

Laboratory Work-up & EKG History

Most recent date labs were performed: _____ Most recent EKG: _____

Results of Labs: ☐ WNL ☐ ABNL _____

Results of EKG: ☐ WNL ☐ ABNL _____

☐ Patient requested to bring in copies of lab work and/or EKG results at next visit

☐ Patient required to have lab work to include:

☐ CMP ☐ CBC ☐ LFT ☐ Thyroid Functions (TSH, free T3/T4, reverse T3)

☐ Testosterone ☐ HbA1C ☐ Vitamin D level ☐ Other: _____

☐ EKG ☐ Stress test ☐ Echo

PRESCRIPTION MEDICATION REVIEW

For your safety and treatment in our program, please mark **YES or NO** for **ANY and ALL medications** you are **CURRENTLY prescribed** or **have been prescribed in the PAST YEAR** (past 12 months).

MEDICATION	YES	NO	MEDICATION	YES	NO
Abstral (Fentanyl Transmucosal)			Lunesta		
Adderall (Dextroamphetamine)			Marinol (Dronabinol)		
Adipex-P (Phentermine)			Meperidine (Demerol)		
Alprazolam (Xanax)			Methadone		
Ambien (Zolpidem)			Methocarbamol (Robaxin)		
Amphetamines			Methylphenidate		
Ativan (Lorazepam)			Midazolam (Versed)		
Avinza (Morphine Sulfate)			Morphine		
Bontril (Phendimetrazine)			MS Contin/MS IR		
Butrans(Buprenorphine)			Naltrexone (Vivitrol/ReVia)		
Buprenex (Buprenorphine)			Neurontin (Gabapentin)		
Butalbital			Norco (Hydrocodone/Acetaminophen)		
Butorphanol			Norflex (Orphenadrine)		
Carisoprodol (Soma)			Nucynta (Tapentadol)		
Clonazepam (Klonopin)			Numorphone		
Clorazepate (Tranzene)			Orphenadrine		
Codeine			Oxycodone		
Concerta (Methylphenidate)			Oxycontin		
Cyclobenzaprine (Flexeril)			Oxymorphone		
Darvocet			Percocet (Oxycodone/Acetaminophen)		
Darvon			Percodan (Oxycodone/Aspirin)		
Demerol (Meperidine)			Propoxyphene (Darvon)		
Dexedrine (Dextromethamphetamine)			Rozerem		
Diazepam (Valium)			Revia		
Didrex (Benzphetamine)			Robaxin (Methocarbamol)		
Dilaudid (Hydromorphone)			Roxicet		
Dolophine (Methadone)			Roxicodone		
Duragesic (Fentanyl Transderm)			Soma (Carisoprodol)		
Duramorph			Stadol		
Endocet (Oxycodone/Acetaminophen)			Suboxone		
Esgic/Esgic plus			Subutex		
Fastin			Talacen (Pentazocine/Acetaminophen)		
Fentanyl			Talwin (Pentazocine)		
Fioricet/Fiorinal			Temazepam		
Flexeril (Cyclobenzaprine)			Tenuate		
Gabapentin (Neurontin)			Toradol		
Halcion (Triazolam)			Tramadol		
Hydrocodone (Lortab/Lorcet/Vicodin)			Triazolam		
Hydromorphone			Tylenol w/codeine (Tylenol #3)		
Ionamin			Tylox		
Kadian (Morphine)			Ultram (Tramadol)		
Ketorolac (Toradol)			Ultracet (Tramadol/Acetaminophen)		
Klonopin (Clonazepam)			Valium (Diazepam)		
Librium (Clordiazepoxide)			Vicodin (Hydrocodone)		
Lorazepam (Ativan)			Vivitrol		
Lorcet			Xanax		
Lortab					

Please list any additional medications you are **CURRENTLY prescribed** or **have been prescribed** in the PAST YEAR.

_____

I,_____, verify I have noted any medications I **am CURRENTLY taking** or **have TAKEN** in the past 12 months.

Patient Signature: _____

Date_____

Witness_____

Spokane Wellness Center

INFORMED CONSENT FOR TREATMENT

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the use of medicines, length of use of medicine, or medication dosing may be used in an "off label" manner.

This means the provider may be using the medicines safely in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine. Please note that the use of medications for weight loss is optional, and no weight loss treatment (including use of medications) guarantees successful weight loss.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.
2. Devote the time and effort necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal provider if necessary.
4. Make and keep follow-up appointments so that we can help you the best, allowing necessary blood tests as needed. Patients more than 15 minutes late for an appointment may be rescheduled to another day.
5. Advise the clinic staff and dr. of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal provider of your weight loss efforts and have or establish a primary provider before beginning this program.

Possible Side Effects

1. Reduced weight. By reducing your caloric intake, you may see a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects. This will be closely monitored as safety is our number one priority.

2. Reduced potassium levels or other electrolyte abnormalities. We monitor electrolyte levels and correct them if they become too low. If they were not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.

3. Gallstones. Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary provider or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.

4. Pancreatitis. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary provider if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.

5. Pregnancy. Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.

6. Sudden death. Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.

7. Risk of weight gain – Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued. We will provide you with a plan to prevent weight from returning.

Patient _____ Date: _____

Spokane Wellness Center

3324 S Grand BLVD
Spokane, WA 99203
PHONE: 509-904-1644 FAX: 509-904-1676

I,_____, wish to enter into the weight loss program directed by Bradley Hilliard-Lythgoe, ARNP. I understand this program includes diet, exercise, behavioral & lifestyle changes, and appetite suppressants when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and illegal.

Appetite suppressants are controlled substances that are regulated by State and Federal Laws. I understand pursuant to State and Federal Laws prescriptions for controlled substances cannot be filled any sooner than once every four weeks. I understand I will not and cannot, for any reason, receive refills on prescriptions for appetite suppressants any earlier than once every four weeks.

I understand that I may be offered to have my appetite suppressant filled and dispensed onsite and I may be offered a service to have it delivered to me weekly. If and when this service is available it is not included in the overall cost of the program and can be discontinued and continued at any time.

I understand that it is illegal to obtain appetite suppressants from more than one provider and agree I will not obtain any appetite suppressants from other prescribing providers. I further understand it is illegal to use more than one pharmacy to have multiple prescriptions filled for appetite suppressants. If I choose to have my prescription filled outside of Spoken Wellness Center and receive a written prescription, I also agree to use only one pharmacy in Washington to have the prescriptions filled.

I agree to only participate in the weight management program directed by Bradley Hilliard-Lythgoe, ARNP. I understand it is illegal to participate in any other weight management program that uses appetite suppressants while I am participating in the weight management program directed by Bradley Hilliard-Lythgoe, ARNP.

I understand that if I participate in the acquisition of appetite suppressants from multiple healthcare providers, for any reason, I am participating in an illegal action and may be held liable for criminal activity.

I understand that Bradley Hilliard-Lythgoe, ARNP and/or his staff have access to the states database of prescribed and dispensing repository and will time from time check to verify there are not multiple prescribers. If it is found there is use or abuse I can be discharged from the practice without warning.

Signature of Participant: _____
Date _____
Witness: _____
Date _____

Spokane Wellness Center

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UNDERSTANDING RULES AND LAWS FOR CONTROLLED MEDICATIONS

I understand that State and Federal law requires providers prescribing controlled medications (including weight loss medications) to monitor patients' use of these medications. This monitoring includes an initial drug screening panel & State Prescribing Repository report. I understand the State Prescribing Repository reports list what controlled substance prescriptions I have filled in the past several years. Further monitoring may include random drug screens, random pill counts, and repeat State Prescribing Repository reports every three months while in the Spokane Wellness Center program. Therefore, I understand that I am to bring in my unused weight loss medications to my appointments as they may be randomly required. I will cooperate with random pill counts. I will allow random drug tests of my urine and/or blood. I understand that this required monitoring could result in the delay and/or inability of my provider to prescribe these types of medications to me.

I understand that weight loss medications may assist in weight loss, but that there is no guarantee they will do so. I understand weight loss medications can only be used with proper nutritional and behavioral changes. Failure to comply with nutritional and behavioral changes may result in provider discontinuing medication. If weight loss is not improved with use of medications, I understand my provider will need to stop or change medications.

I understand my provider can discontinue weight loss medications at any time & will do so if weight loss plateaus. I understand that if weight loss medications are used, the plan is to use them only during weight loss and then to taper off of them once goals have been met. I will be evaluated monthly to see if medications can and should be refilled.

I understand that weight loss medications are just one option to assist in weight loss, but are not required to lose weight. There are many options for weight loss although all patients will be instructed on nutritional, behavioral, and psychological changes. Just like any medication, weight loss medications can have a risk of side effects. Such side effects may include (but are not limited to), dry mouth, constipation, anxiety, jittery sensation, headache, insomnia, allergic reaction, heart palpitation (rare), elevated blood pressure (rare).

Addiction is listed as a potential side effect (although this has not been reported if used as prescribed.) I understand it is my responsibility to notify my Spokane Wellness Center program provider if I have any side effects.

If weight loss medications are used over 1 month, they should be tapered off unless you become pregnant or have a serious side effect from the medication in which case they can be stopped immediately. Failure to taper off of weight loss medications may result in rebound hunger, fatigue, depression, gain in weight, and other symptoms. I understand that if I desire to discontinue medications for any reason (including simple inability to continue program), I will contact Spokane Wellness Center to obtain a proper exit plan based on my current medical conditions.

Unused medications may be returned to Spokane Wellness Center program for proper disposal, or follow the guidelines at www.fda.gov/consumer.

Females only: I certify that I am not pregnant. I agree and understand that I must notify my prescriber if l plan to become pregnant or am unsure if I am pregnant. I agree not to take weight loss medications if I become pregnant.

My signature placed on this contract indicates that I fully understand each statement and have had the opportunity to ask any questions pertaining to this. All of my questions have been answered to my satisfaction. I understand that if I break any part of this agreement, I may be discharged from my provider's care.

Patient's name (print) _____

Patient's signature _____

Date_____

Spokane Wellness Center

YOUR RIGHTS AND CONFIDENTIALITY

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal provider must be able to assume your medical care. From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

Please note that our Providers do not take calls outside Spokane Wellness Center's office hours. If you feel you are experiencing a medical emergency at any time, go to the nearest emergency room immediately for treatment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION (HIPAA)

Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody, coroners, medical examiners, funeral directors.

Uses and Disclosures of information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. (Disaster Relief & Persons Involved in your case)

If you object, please notify the Privacy Contact identified at the end of this document.

Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Person(s) Authorized to Receive Information:_____

Provider Office(s) Authorized to Receive Medical Information:_____

Medical Residents, Medical Students, and Training Providers may observe or participate in your treatment or use your PHI to assist in their training.

You have the right to refuse to be examined, observed, or treated by them.

Newsletter and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Your Right Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.
8. To receive notice of a breach
9. Right to restrict certain disclosure to your health plan.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Privacy Officer Contact: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our office located at 3324 S Grand BLVD, Spokane, WA 99203, PHONE: 509- 904-1644 FAX: 509-904-1676

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

Patient Signature_____ Date_____

Spokane Wellness Center

RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PROVIDER DECIDE UPON THEIR USE NOW OR IN THEFUTURE.

Many weight loss medications are considered "controlled medications." By law, a controlled medication can only be received from one facility at the same time. I agree that only Spokane Wellness Center will prescribe scheduled weight loss medications for me. I agree that it is my responsibility to inform my provider and any other providers from whom I receive treatment of this contract, and that it is my responsibility to inform any and all providers from whom I receive treatment if I am prescribed and/or taking any scheduled medications. Spokane Wellness Center may also notify my other providers of the terms of this contract.

I understand that the use of weight loss medications is contraindicated with certain medical histories, allergies, or other medication use. I agree that I will be completely honest in disclosing this information & will notify my Spokane Wellness Center provider of changes to my medical history or new medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed by Spokane Wellness Center. I understand that taking medications in any way other than prescribed may be dangerous to my health. I understand medications are typically only considered after a trial of weight loss with only nutritional/behavioral changes. If benefit outweighs the risks after this point, the lowest effective dose will be tried prior to increasing dosages.

I agree to arrange for prescription refills for scheduled medications from Spokane Wellness Center only during regular clinic hours. I understand that controlled medications are not refilled in advance to time of refill. Medications are typically dispensed only in one month increments and only via provider approval during provider appointment with appropriate vital signs. I understand that missing my appointment may mean being out of the medications for a small time period as controlled medications are not refilled via phone. I understand that Spokane Wellness Center is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

I understand that medication prescriptions can be filled typically at Spokane Wellness Center or another pharmacy of my choice. If I use a pharmacy other than Spokane Wellness Center, I agree to use only one pharmacy to fill any weight loss scheduled prescriptions and I give my permission for Spokane Wellness Center to notify area pharmacies of the terms of this agreement.

I will not use any illegal drugs or substances. I will not obtain or use any controlled substances illegally.

I will not share, sell, or trade my medication with anyone. I understand doing so is illegal, will result in my discharge from my provider's care, and may cause harm to the other person including possible death. I will not allow any other individual to take my medication under any circumstances.

I understand that the use of many weight loss medications beyond 3 months is considered off-label usage. I understand I am to report any side effects or adverse reactions of medications to my Spokane Wellness Center provider.

I authorize my Spokane Wellness Center provider and my pharmacy to cooperate with any investigation of my drug use by legal authorities. This includes, but is not limited to, the release of my medical and pharmacy records and answering questions about me. My provider may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health. I will continue to comply with all parts of the agreement during those evaluation periods.

Patient Signature_____Date_____

How did you hear about us?

__ Provider Referral: Dr/NP/PA_____City: _____

__ Internet Search: _____ Radio: _____

__ Friend/ Family __TV __Drive by __ Florence Freedom

__ Valpak __Reach magazine __ Money Mailer __ Yellow Pages

__ Trade Show/Event:_____Other: _____

E-Mail Address
