Bottoms Down Weight Loss
6323 Memorial Hwy. Ste D-122
Tampa, Fl. 33615
813-884-0900
813-884-0906 (fax)

GENERAL MEDICAL INFORMATION

Name: _____

Reason for today's visit: _____

Current Medications: _____

Allergies to Medications: _____

Other physicians currently treating you: _____

Previous medical problems: _____

Previous surgeries: _____

Are you pregnant or nursing: _____

Do you smoke? _____ No. of years _____ How much? _____

Do you drink alcohol? _____ How many ounces/beers per day? _____

Do you drink coffee? _____ How many cups per day? _____

FAMILY HISTORY

	Father	*Mother*	*Grandparents*	*Siblings*	*Children*
High blood pressure					
Epilepsy					
Cancer					
Eczema/Psoriasis					
Heart attack / Stroke					
Diabetes					
Asthma					
Hay Fever					

PERSONAL MEDICAL HISTORY

Have you ever had any of the following? Please answer with yes or no

Chest pain/pressure/tightening _____
Hypertension _____
Heart attack _____
Stroke _____
Headaches _____
Glaucoma _____
Allergies or Eczema _____
Depression _____
Memory loss _____
Hemorrhoids _____
Kidney disease _____
Shortness of breath _____
TB/Lung disorder _____
Ulcers _____

Blood in stool _____
Asthma _____
Dizzy spells _____
Cancer _____
Diabetes _____
Arthritis _____
Difficulty hearing _____
Anemia _____
Skin disorders _____
Hepatitis _____
Cataracts _____
Digestive problems _____
Frequent urinary infections _____
Other _____

(Below is a Year that you last received, if known)

Smallpox _____
Tetanus _____
Typhoid _____
Polio _____
Influenza _____
Pneumonia _____
Rubella _____
Hepatitis _____

PATIENT CONSENT FORM

*I **_____**, the undersigned, voluntarily consent to participate in a supervised weight loss program provided by:*

Clinic Name: _____

*I understand that this **weight loss program** may include:*

- Nutritional and dietary counseling
- Exercise recommendations
- Behavioral modification strategies
- Use of prescription and/or over-the-counter weight loss medications or supplements (if applicable)
- Medical monitoring, including regular check-ins, or vital sign checks

*I understand that the **potential benefits** of this program may include:*

- Reduction in body weight and body fat
- Improved physical health and energy levels
- Decrease in risk factors related to chronic diseases (e.g., diabetes, hypertension, high cholesterol)

*I understand that potential **risks or side effects** may include, but are not limited to:*

- Fatigue, dizziness, dry mouth, or weakness
- Gastrointestinal discomfort or changes in bowel habits
- Mood changes or emotional distress
- Adverse reactions to prescribed medications or supplements
- Temporary or permanent changes in metabolism or appetite
- Possible weight regain after treatment ends

*I understand that **results are not guaranteed**, and weight loss outcomes may vary.*

I confirm that:

- I am signing this consent voluntarily and without coercion
- I have read and understand this form

Patient Signature: _____
Date: _____

501.0575 WEIGHT-LOSS CONSUMER BILL OF RIGHTS

(1) The Weight-Loss Consumer Bill of Rights shall consist of the following provisions:

(A) Warning: Rapid Weight Loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ 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.

(B) Consult your personal physician before starting any weight-loss program.

(C) Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss.

(D) Qualifications of this provider are available upon request.

(E) You have a right to:

1. Ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components.

2. Receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests.

3. Know the actual or estimated duration of the program.

4. Know the name, address, and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468.505 (1) (j), Florida Statutes.

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.The practice utilizes a few vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

3. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or any of the other health care providers.Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.We agree to provide patients with access to their records in accordance with state and federal laws.We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, on _____, hereby consent and acknowledge my agreement to the terms set forth in this HIPAA Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

DEMOGRAPHICS

Date: _____

Name: _____

Cell Phone Number: _____

Email Address: _____

Date of Birth: _____/_____/_____ Marital Status: _____

Age: _____ Gender: _____ Race/Ethnicity: _____

Street Address: _____

City: _____ State: _____Zip: _____

Occupation: _____

With whom may we share information about your account? Name: _____

Relationship: _____ Phone: _____

Email address: _____

With whom may we share medical records? Name: _____

Relationship: _____ Phone: _____

Email address: _____

How did you hear about us? _____

FINANCIAL POLICY

1. **PAYMENT** is due at the time services are rendered. We will accept cash, check, or credit card. We may ask you for a copy of an ID card or license due to the many cases of identity theft. (Please do not be offended!)

2. **RETURNED CHECKS** will incur a $25.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $25.00 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $25.00 fee and collections action.

3. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours in advance, or if you are a no-show, we will assess you a $25.00 missed appointment fee.

4. **GROUPON OR LIVING SOCIAL VOUCHERS:** Once vouchers are redeemed, they must be used within a 60-day period, starting from the date of the first visit. Only ONE Groupon or Living Social voucher (including in-house deal), is allowed per patient per lifetime!

5. **ADVANCE PAYMENTS:** Any advance payments made to your account, must be used within 90 days, starting from the date of your last visit. After 90 days, all remaining credits will expire.

6. **RETURN PATIENTS:** Any patient that returns after 90 days, will pay a return fee of $69.00. This $69.00 charge will include 1 week of Phentermine and 1 fat burning injection.

7. **No Returns:** All sales are final, please carefully review your order before confirming your purchase. We do not offer returns, refunds, or exchanges for any products or service we sell.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print your name