Patient Information Form

Patient Name: (Last)______________________________(First)____________________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ____ State: _________________ Zip: _______________

Home Phone: _______________________________Cellular: _____________________________

May we leave a message at this number? ______Y_____N May we leave a message at this number? _____Y _____N

Date of Birth: ___________Age: _____Sex: M F Email address______________________________

Education: High School/Technical School 2-yr College 4-yr College Graduate School (Circle the highest level achieved)

Employment Information:

Patient Employer: ________________________________ Occupation: _____________________________

Employer Address: ____

City: ____ State: ______________ Zip: _______________

Work phone No: __________________________________Ext. ____________________________________

Social Security: __________________________________Drivers License: __________________________

In Case of Emergency:

Name: ___________________________________Relationship: _______________ Phone: _____________

Family Physician: ____ Phone: _____________

Who Referred You or How Did You Hear About Us____

Financial Policy:

Thank you for selecting Cesar A. Lara, MD; Weight Management for your medical weight loss journey. We are honored to be of service to you and your family. Please be advised that payment for all services is due in full at the time services are rendered. Our services are not reimbursed by insurance, and we do not provide or complete claim forms for insurance purposes. For your convenience, we accept Visa, MasterCard, Discover, American Express, as well as Care Credit and personal checks. No refunds are given at any time for any reason.
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

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

New Patient History (*Please **PRINT** All information clearly*) ***Date:___/___/___***

Name____Date of Birth______/_____/_______Age______

Occupation:____________________________________Primary Physician____________________________

Medical History:

What medications are you allergic to? ____

What foods are you allergic to? ____

Current meds and doses:	Taking it for?	**Over the counter meds/vitamins/herbals**
1) _________________________	______________	1)___________________________
2)__________________________	______________	2)___________________________
3)__________________________	______________	3)___________________________
4)__________________________	______________	4)___________________________
5)__________________________	______________	5)___________________________
6)__________________________	______________	6)___________________________
7)__________________________	______________	7)___________________________
8)__________________________	______________	8)___________________________
9)__________________________	______________	9)___________________________
10)_________________________	______________	10)__________________________

Please **check** the **medical conditions** that **YOU** have been diagnosed with in the past or currently.

- Past or current drug or alcohol problems
  - Ever treated for abuse or dependency
    Y N
- Depression or anxiety
- Diabetes/ Gestational Diabetes
- Insulin Resistance/Prediabetes/Borderline Diabetes/Dysmetabolic Syndrome
- Polycystic Ovarian Syndrome
- Heart Burn
- Glaucoma (Open or Closed Angle?)
- High Cholesterol
- High Blood Pressure
- Heart Disease/Heart Attack/Congestive Heart Failure
- Arrhythmia
- Heart Valve Problems/ Heart Murmurs
- Asthma
- History of passing out (syncope)
- Lung disease COPD Emphysema (Type:___________________________)
- ADHD (Attention deficit disorder)
- Bipolarism or other psychiatric conditions? _____________________
- Kidney Diseases (Type:___________________________)
- Liver Diseases (Type:___________________________)
- Obstructive sleep apnea/ Insomnia/ other sleep disorders
- Thyroid Disorders (Low or High or Other:___________________________)
- Other Chronic Medical Conditions:______________________

List any surgeries/hospitalizations you have had in the past____
____
____

Have you had (date): Colonoscopy_________Cardiac Catheterization___________Stress Test_________

Any other procedures: ____

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Social History:

Married Single Divorced Separated How long? _________ #Children____________

Ladies: Are you pregnant______Breastfeeding________
Date of last mammogram___________________
Do you have abnormal periods_______________
Menopausal or Perimenopausal_______________

Do you drink coffee or tea? Yes No How much daily?
Do you drink cola or energy drinks? Yes No How much daily?
Do you drink alcohol? Yes No How much daily? _______________Weekly? ______________________
Do you smoke? Yes No How much daily _____________ What age did you begin _______
When did you quit?____________________

Family History:

Who in your FAMILY has had the following? (Mom, dad, siblings, aunts/uncles, cousins, grandparents)

- Heart Disease/Heart Attack/ Congestive Heart Failure___________________
- Cancer: (list type) ____________________
- Hypothyroidism________________________
- High Cholesterol____________________
- High Blood Pressure____________________
- Sudden death < age 40 from medical condition___________Stroke____________________
- Diabetes or "borderline diabetes"__________________________
- Mental illness (depression, bipolar, etc.) ____________________
- Who in family struggles with weight? ____
- Other family medical conditions____

Your Current Health:

Please circle if you have been having any of the following **symptoms**

1) Weakness
2) Dry, Coarse skin
3) Tired/fatigue
4) Slow speech
5) Slow movement
6) Coldness and cold skin
7) Diminished sweating
8) Thick tongue
9) Coarse hair
10) Pale skin
11) Constipation
12) Gain in weight
13) Loss of hair
14) Difficult breathing
15) Swollen feet
16) Hoarseness
17) Loss of appetite
18) Poor memory
19) Nervousness
20) Heart palpitations
21) Brittle nails
22) Swelling of face & eyelids
23) Excessive or painful menses
24) Emotional Instability
25) Depression
26) Headaches

Please check here if none of the above 26 symptoms apply to you

How *often* to you **exercise**?

- Daily
- 4-5 x per wk
- 2-3 x per wk
- 1-2 x per wk
- None

What is the *intensity*?

- Very hard: Sprinting, speed swimming, spinning
- Moderately hard: Running, high aerobics, some Zumba
- Moderate: Speed walking, biking, low impact aerobics and some Zumba
- Light: Walking, golfing, doubles tennis
- Daily living activities: Cleaning, gardening, work, caring for children

For *how long*?

- 45-60 min
- 30-45 min
- 20-30 min
- 10-20 min
- <10 min

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Diet and Nutritional History:

What is your goal weight? ____________ lbs   When were you last at your goal weight?_______lbs

What is your lifetime non-pregnant maximum weight?________________lbs

Have you ever had:

Bulimia	Y	N
Binge Eating Disorder	Y	N
Anorexia	Y	N

What weight loss medications or programs have you tried in the past?

_________________________ _____________________________ ____________________________

Any problems associated with previously used medications listed above? N   Y (if yes explain)

____

Of above listed programs and/or medications, what about them worked best for you?

____

Why do you think you struggle with your weight? ____

What is a typical day of food like?

Breakfast____Lunch____________________________________

Snacks____Dinner____________________________________

Are you a night time eater or craver?   Y   N

What types of foods do you typically eat at night? ____

Overall goals: What do you hope to accomplish by being in our program?

____
____
____
____

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I,____ (patient or patient's guardian) authorize Cesar A. Lara, MD; Weight Management, 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 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

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

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 medicines and length of medicine usage may be used in an “off label” manner. This means the doctor may be using the medicines 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.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, lifestyle patterns, medication or drug usage (including any weight loss meds, DEA controlled meds, stimulant type medications and any or all habit forming drugs) to help us best 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 physician if necessary
4. Make and keep follow up appointments and allow necessary blood tests as needed.
5. Advise the clinic staff and doctor of any concerns, problems, complaints, symptoms or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a personal physician before beginning this program.

I ___________________________________ authorize César A. Lara, M.D.; Weight Management 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, 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.

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Possible Side Effects

1. **Reduced weight**. By reducing your caloric intake may give 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/brittle hair, or hair loss. Medication side effects may include any of the above, dry mouth, mild headaches, and very rarely, a racing or pounding heart rate or an election in blood pressure.
2. **Reduced potassium levels or other electrolyte abnormalities**. 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 may need to follow your levels with occasional blood testing.
3. **Gallstones**. Overweight people are at risk for having or developing gallstones. These can develop in overweight patients. 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. Notify your doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea and vomiting. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medication or surgery to remove gallbladder.
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.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulation 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. 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, heart disease, have a higher risk of sudden death and development of a serious and potentially fatal disease, 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 regain**. Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless some type of maintenance program and long-term efforts controlling the weight are continued.

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: ______________________________

Witness: ____________________________ Patient: ____________________________

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Your Rights and Confidentiality

You have the right to leave treatment at any time without penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician 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

HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY B E USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Information That We Make Without Written Authorization: Treatment, payment, healthcare operations, 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 persons in police custody.

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. 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 of 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.

Your Rights 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 Offer.

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 your insurance rates.

Complaints: You may complain to us of 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.

Entities to Whom this Notice Applies: This notice applies to César A. Lara, M.D.; Center for Weight Management, their associated clinics, the physicians, employees and volunteers who work there.

Privacy Officer Contact: If you have any questions about this notice, to 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 about, please contact our Privacy Officer Christina Bertsos: Address 1217 Ewing Ave, Clearwater, FL 33756; (727) 446-3021.

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

______________________________ ____________________

Patient Signature Date

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________________________, have received a copy of the César A. Lara, MD; Weight Management Notice of Privacy Practices. In addition, ***I specifically authorize only the following individuals*** to have access to my medical information.

I.e. (re) schedule (cancel) appointments, pick up any medical documents, tend payment, or disclose any medical information to the individuals listed.

List of authorized individuals as follows

- ____
- ____
- ____
- ____
- ____

________________________________ ________________
Signature of Patient **Date**

________________________________ ____________________
Witness **Phone Number**

CÉSAR A. LARA M.D.
WEIGHT MANAGEMENT

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ 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. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; 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.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

_______________________________________ ________________________________
Patient's Signature Date

Patient Name:____ D.O.B _____________________