Eternity Med Spa
LASER HAIR & SKIN CARE

Physician Assisted Weight Loss Program

Patient Name: _____ Date: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

DL / ID #: _____ **Phone Number:** _____

Birthdate: _____ Age: _____ E-mail: _____

Employment Information:

Patient Employer: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Work Phone Number: _____ Is it ok to contact you at work? _____

In Case of Emergency:

Name: _____Relationship: _____Phone: _____

Patient's Spouse: _____Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

Groupon # _____ Living Social # _____

AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENT'S CONDITION/TREATMENT

In accordance with the Medical Privacy Act of California, our staff is unable to release any information pertaining to your medical care without your consent. If you authorize us to release information regarding your care to someone other than yourself, please complete the following authorization:

I hereby authorize Physician's and/or staff of Dr. Gilbert Martinez, to release information pertaining to my condition and/or care to only those family members, physicians and/or others involved with my care as listed below:

_____

Name **Relationship** **Telephone Number**

_____

Patient's Signature or Authorized Representative **Date**

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Present Status:

At the present time what is the state of your health? Excellent Good Fair Poor

Are you under a doctor's care at the present time? Yes No

If yes, why? _____

Please list all medications and supplements which you are currently taking:

_____

_____

Please list all known allergies to medications, foods or other allergens:

_____

Medical History (circle all that apply)

High Blood Pressure	Trouble Sleeping	Tonsillitis
Diabetes	Insomnia	Arthritis
Heart Disease	Scarlet Fever	Osteoporosis
Frequent Headaches	Whooping Cough	Alcohol Abuse
Migraines	Bleeding Disorder	Blood Transfusion
Glaucoma	Gout	Cancer
Edema/Swelling	Constipation	Pneumonia
Depression	Gallbladder Disease	Polio
Kidney Disease	Liver Disease	Drug Abuse
Lung Disease	Chicken Pox	Eating Disorder
Rheumatic Fever	Psychiatric Illness	Tuberculosis
Ulcers	Thyroid Disease	Other:_____
Anemia	Jaundice	_____

Ob/Gyn History:

Last Menstrual Period: _____ Is there any chance you might be pregnant? _____

How many pregnancies have you had? _____

How many live births? _____

Current Method of Birth Control? _____ Last Pap smear? _____

General Medical History

Please list all medical conditions:

_____

Please list all surgeries:_____

Please detail any other important medical information about yourself:

_____

Family History:

	Current Age	Health	Disease (or cause of death)
Father:			
Mother:			
Brothers:			
Sisters:			

Has any relative ever had any of the following?

Asthma	Yes No	Who?	_____
Epilepsy	Yes No	Who?	_____
High Blood Pressure	Yes No	Who?	_____
Kidney Disease	Yes No	Who?	_____
Diabetes	Yes No	Who?	_____
Tuberculosis	Yes No	Who?	_____
Psychiatric Disorder	Yes No	Who?	_____
Heart Disease/Stroke	Yes No	Who?	_____

Nutrition Evaluation:

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

Birth Weight: _____ Weight at age 20? _____ Weight 1 year ago? _____

What is the main reason for your decision to lose weight? _____

_____

When did you begin gaining excess weight? (Give reasons, if known) _____

_____

Previous diets you have followed (give dates and results of your weight loss):

_____

_____

Is your spouse, fiancée or partner overweight? Yes No

How often do you eat? _____

What restaurants do you frequent? _____

Who plans meals? _____ Cooks? _____ Shops? _____

Food you crave: _____

Any specific time of day or month you crave food? _____

Do you drink:

Coffee or Tea	Yes	No	How much daily? _____
Cola Drinks	Yes	No	How much daily? _____
Alcohol	Yes	No	Type_____Amt_____How Often_____

What are your worst food habits? _____

_____

_____

When you are under a stressful situation at work or family related, do you tend to eat more? Yes No
Explain: _____

_____

_____

_____

Are you currently experiencing a stressful situation or emotional upset? Yes No
Explain: _____

_____

Are you a smoker or have you ever been? Yes No

If so, list number of cigarettes per day, how long, and if no longer smoking when you stopped:

_____

_____

Typical Breakfast Typical Lunch Typical Dinner

_____

_____

Describe your energy level: _____

Activity Level: (answer only one)

_____ Inactive- No regular physical activity with a sit down job
_____ Light Activity- No organized physical activity during leisure time.
_____ Moderate Activity- Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy Activity- Consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____ Vigorous Activity- participation in extensive physical exercises for at least 60 minutes per session.

Please describe any regular exercise in which you engage in routinely:

_____

Have you ever tried prescription weight loss medication? Yes No

If yes, when & name of medication:

_____

Do you have a good support system at home to help motivate healthy eating & exercise? Explain:

_____

Have you seen a Nutritionist before: Yes No When?

_____

How often do you snack in between meals, and what do you snack on?

_____

_____

How many glasses of water do you drink per day? _____

Do you have trouble falling asleep at night? _____

Staying asleep? _____

Patient Signature Date

Dr. Martinez will review this information, which will assist him in developing a safe and effective weight loss program individualized for you.

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Financial Policy

YOUR RESPONSIBILITY
You are financially responsible for all services we provide for you.

METHODS OF PAYMENT
We accept cash, all major credit cards and Care Credit. I am sorry, but we do not accept checks.

MISSED APPOINTMENTS AND NO SHOWS
We see patients on an appointment basis and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment. Although we do our best to ensure a courtesy reminder call is given to remind you of your upcoming appointment, we are not responsible for a missed appointment if one was not given. **Patient agrees to pay a fee of $25 or (for appointments scheduled for 30 minutes or longer) forfeit one session of your laser treatment package every time proper notice is not given.**

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the appointment is responsible for payment, regardless of the terms of the custodial agreement.

INFORMATION CHANGE
Please advise us of any address or phone number changes promptly.

COLLECTION PROCEDURES
Members of our billing department are always available to help you with questions and or payment options. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. All prior balances must be resolved before being seen by our physician or in our practice again.

I have read and understand the financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-tie by the practice. I hereby voluntarily consent to healthcare encompassing recommendations and treatment by my physicians, his/her associates, assistants or other healthcare providers, as may be necessary in my physician's judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____

Signature of Patient or Guardian if a minor Date

_____

Please print patient name

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PATIENT HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights Section describing your rights under law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.
By signing this form, you consent to our use and disclosures of protected health information about you for treatment, payment and healthcare operations. You have right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
Protected health information may be disclosed or used for treatment, payment or healthcare operations. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice. The practice reserves the right to change the Notice of Privacy Policies. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

_____ _____

Patient Signature Date

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I, _____ authorize Dr. Gilbert Martinez, and whomever he may designate to help 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 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. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, fee and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 that 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 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.

Patient: _____ Witness: _____

Date: _____ Time: _____