SOLUTIONS WEIGHT LOSS
REAL DOCTORS! REAL RESULTS!

Health History

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

Is your general state of health: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

In order to provide you the most personalized experience, please accurately complete the following patient information:

First name:_____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

DOB: _____/_____/_____ Age: _____ Height: _____ Gender: M ❒ F ❒

Employer _____ Occupation _____ Work Phone: _____

Email: _____ Cell: _____

Marital Status: Married ❒ Single ❒ Divorced ❒ Widowed ❒

Emergency Contact:_____Relationship_____ Cell: _____

How did you hear about us? Web Search ❒ Friend or Family ❒ Walk-in/Drive by ❒ Advertisement ❒

Insurance Policy

Medical insurance policies typically do not cover weight management or related expenses, including laboratory testing, electrocardiograms, prescription medication or related supplements. Your primary diagnosis is overweight or obesity. Payment is due at the time of service. Appropriate receipt of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies. Changes to "Codes" will not be made for the use of any insurance company. Insurance companies may reimburse patient for expenses related to weight management; for instance, if weight management is part of the treatment of a co-morbid condition. Reimbursement will not be made from the insurance company to the physician. **Please note that Solutions Weight Loss will not present a bill to any insurance company for weight management services or related charges. Also, Solutions Weight Loss will not be obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard. (THIS ALSO APPLIES TO ALL AESTHETIC SERVICES AND PRODUCTS)**

PATIENT STATEMENT OF UNDERSTANDING

I have read and fully understand the above information related to insurance and participation in Solutions Weight Loss Program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of these receipts and and limitations as described in this document. I accept these specific policy rules.

_____	_____	_____
Print Name	Signature	Date

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Patient Registration

Please CIRCLE all that apply ◉

Alcohol Abuse	Convulsions	Fainting Spells	Insomnia	Nervousness
Anemia	Depression	Fatigue	Panic Attacks	Obesity
Arthritis	Diabetes	Food Allergies	Anorexia	Rashes
Asthma	Diarrhea	UTI	Gallbladder dz.	**Irregular Pulse**
Bleeding Dz.	Dizzy Spells	Glaucoma	Kidney Disease	Shortness of breath
Bloody Stool	Menses irregular	Headaches	Liver Disease	Sleep Apnea
Blood Clots	Ovarian Cysts	**Heart Disease**	Lung Disease	Stroke
Cancer	**Drug Addiction**	Mental Illness	Thyroid Disease	**Eating Disorder**
Chest Pain	**Hypertension**	Epilepsy	Hypoglycemia	Anxiety

FOR WOMEN ONLY: Are you ❒pregnant ❒attempting pregnancy ❒breastfeeding

Please list ALL current **PRESCRIPTION** and **NON-PRESCRIPTION** medications:

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1			3		
2			4		

List all allergies to medication	Type of Reaction
1	
2	

Hospitalizations and Surgeries	
Year	**Type of surgery and Diagnosis**
1	
2	

Accuracy Agreement: I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.

Signature _____ **Date:**_____

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Florida Statutes 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 11/2 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.

I acknowledge that I have read the above and understand my rights as a consumer. I understand there are many alternatives to losing weight other than the program offered by Solutions Weight Loss, including diet and exercise alone. Despite this, I wish to participate in the program at Solutions Weight Loss.

_____ Date:_____

Print Name Signature

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Permission for Use of Photographs

PLEASE CHECK ONLY ONE BOX BELOW:

❒ I agree to take "Before and After" photos ONLY for my medical chart. They will be confidential and will not be shared with any other party without my consent.

OR

❒ I grant Solutions Weight Loss permission to use my photographs for professional education, marketing and advertising purposes. I understand that my name and personal information will be kept confidential. I. hereby, hold harmless Solutions weight Loss from any detrimental consequences that may be experienced as a result of using that material. I give permission voluntarily and understand that I may withdraw this permission at any time.

_____Date: _____

Print Signature