Before-N-After
Weight Loss | Wellness

Date: _____ Clinic Location: Murrieta Menifee San Marcos

Patient Name _____ DOB__/___/____ Age_____

Mailing Address_____

City_____ State_____ Zip Code_____

Ph # ( ) _____--_____ Is it O.K. to contact you via phone if necessary.

Email: _____@_____

Before-N-After frowns on SPAM. However, Email correspondence is an efficient way to communicate with clients so we would like to be able to send you occasional Emails to inform you of urgent program information, special events, medication changes and special pricing? Is it O.K. to use Email correspondence for these reasons? □ Yes □ No

How were you referred

□ Friend (please specify name): _____

□ Radio □ Website □ Other: _____

Agreement and Consent for Treatment

It is understood and agreed that I authorize and direct Before-N-After Medical group, its associates and employees to provide services that in their judgment, are considered advisable or necessary for the patient whose name appears above. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained and the nature; purpose and risks of the procedures and possibilities of complications have been explained to me. It is understood and agreed that any claim or dispute in connection with treatment involving Before-N-After and/or its associates and employees participating in my examination or care shall be settled under Before-N-After Weight Loss and Wellness Medical Corporation physician's medical insurance coverage. Any personal accident or injury that may occur on the premises shall be settled with Before-N-After, LLC and no claim be brought against the attending physician of the program. Patient agrees that any claims and controversies that may arise from his/her care will be decided through binding arbitration.

_____ _____

Patient Signature

_____ _____

Witness Signature

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Patient Non-Disclosure Statement

I, _____ understand that my provider has the ability to provide me with some of the medications that I may need for my treatment. However, I understand that I will always be given the option to receive a written prescription and drug information sheet and that I may have the prescription filled at a pharmacy of my choice.

Signature:_____ Date: _____

Yo,_____entiendo que mi Médico tiene la habilidad de proveerme con alguna de la medicina necesaria para mi tratamiento. Sin embargo, entiendo que siempre tendre la opción de recibir una prescripcion escrita y la hoja de información sobre las drogas, para que pueda adquirila en la farmacia de mi preferencia.

Firma :_____ Fecha:_____

(TO BE PLACED IN PATIENT FILE) (PARA SER COLOCADO EN EL ARCHIVO DEL PACIENTE)

Pharmacy Laws California Edition/Business and Professions Health and Safety Civil Article 12 Prescriber Dispensing Part 4170 (6)

HIPAA Privacy Statement

NOTICE OF PRIVACY PRACTICES

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

Before-N-After Weight Loss and Wellness Center, LLC respects you and your privacy. We are committed to keeping all information received or created confidential.

We want you to have a clear understanding of how we use and safeguard information about you. This Notice of Privacy Practices describes how we may use and disclose your protected health information in order to carry out services, voucher for payment and for other purposes permitted or required by law. It also describes your rights to access and control your information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of the legal duties and privacy practices with respect to your protected health information.

Health information means any information, whether oral or recorded in any form, that is created or received by Before-N-After, relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

How Your Protected Health Information May Be Used or Disclosed

Before-N-After uses protected health information about you for services, payment and regular health care operation purposes. We do not require authorization to use your protected health information for these purposes.

Services
Providing you with care and services related to your health, such as working with other agencies involved with the delivery of services.

Payment
Information needed for billing, insurance, or compensation for services, if necessary. We may provide necessary portions of your protected health information to our billing department and/or accountant to get paid/reimbursed for the services we provide to you.

Regular Health Care Operations
Activities that may include quality assessment, program evaluation and auditing.

Emergency Care
To help you obtain treatment in a medical emergency. An authorization is required as soon as reasonably possible after the emergency and the provider should document the reasons as to why the authorization could not be received.

When Legally Necessary
If required by federal, state or local law. We may make disclosures when a law requires that we report information to government agencies or law enforcement personnel about victims of abuse, neglect, domestic violence or to avoid serious threat to health or safety of a person or the public.

We may provide protected health information to a family member, friend or other person that you indicate is involved in your services or the payment for your services unless you object, in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

IN ADDITION, ANY ALCOHOL OR SUBSTANCE ABUSE RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42CFR Part II)

ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (Article 27-F)

When Before-N-After May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

- You have the right to inspect and obtain a copy of your health information.
- You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the requested restriction.
- You have a right to request that we amend your health information. An amendment can only be granted if the information requested to be amended is created by Before-N-After.

- You have a right to receive an accounting of disclosures of your health information. This will not include any dates before December 1st, 2007 and cannot be longer than six years from this date.
- You have a right to receive confidential communications of protected health information and the manner in which it is sent to you. Within reason, you have the right to ask that we send information to you at an alternate address (such as requesting that we send information to your work address rather than your home address) or by alternate means (such as by regular mail versus e-mail, if such methods are reasonably available).
- You have a right to a paper copy of this Notice of Privacy Practices. You will be asked to sign an Acknowledgement of Receipt of this Notice.
- You have a right to complain if you believe your privacy rights have been violated or if you are dissatisfied with the services you are receiving. You will not be punished in any way for filing a complaint. (Please refer to our Complaint Form for information regarding internal and/or external complaints.)

Changes to This Notice of Privacy Practices

We are bound by the terms of this notice currently in effect and reserve the right to amend this Notice of Privacy Practices at any time in the future. If such amendment is made, all individuals currently active in our programs will be provided a revised Notice of Privacy Practices by mail or at their next scheduled meeting.

If you have any questions regarding this notice or need further information please contact Tony Rosales at (951) 698-6242 or by writing to Tony Rosales, CEO, Before-N-After Weight Loss and Wellness Management Co., LLC. 25109 Jefferson Ave., Suite 115, Murrieta, Ca 92562

I have read and understand my rights under HIPAA. I understand that a copy of this statement is available upon request. I □ **Do** / □ **Do Not** request a copy of my privacy statement. By not marking either box, it is implied that a copy is NOT requested.

_____ Date_____

Patient Signature

Date

_____ _____

Witness Signature

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MEDICAL HISTORY:

Please check the appropriate box if you have you ever been diagnosed with any of the following:

Diabetes	High Blood Pressure	High Cholesterol
Thyroid Disorder	Angina (chest pain)	Headaches
Irregular Heartbeat	Mood Disorder	Migraines

Please list any other medical conditions or surgeries:

_____
_____

Are you allergic to any medications? ( ) Yes ( ) No

If yes, please list:

_____
_____

Current Medications including over the counter medications, prescription medications, herbals medications and natural supplements:

_____
_____

ARE YOU CURRENTLY PREGNANT? ( ) Yes ( ) No ( ) N/A

DO YOU PLAN TO BECOME PREGNANT IN THE NEXT SIX MONTHS? ( ) Yes ( ) No

(Appetite Suppressants are not indicated in pregnant or breast feeding women)

Do you drink alcohol or use tobacco?_____

Have you ever been **addicted** to alcohol or drugs? ( ) Yes ( ) No

Family Medical History (Parents, Grandparents, Siblings):

_____
_____

Diet and Exercise History

Have you previously tried a Low-Carbohydrate/High Protein Diet? ( ) Yes ( ) No

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What other diet programs have you tried?

_____

_____

Have you previously tried exercise to lose or maintain weight? ( ) Yes ( ) No

Was it successful? ( ) Yes ( ) No

What type of exercise program do you currently participate in?

_____

Have you ever used PRESCRIPTION

Have you ever used any of the following? (Please circle)

Ionamine Fastin Tenuate Temanil Prelude ll Phentermine Meridia Redux Didrex Phendimetrazine Fen-Phen Adipex

Did you experience any side effects? ( ) Yes ( ) No

If yes, please list side effects:

_____

_____

Please list any other questions or concerns?

_____

_____

Date _____ Signed_____
(Patient)

Thank you, your answers will help you and your provider decide on an appropriate weight- loss program.

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RELEASE FOR SERVICE

Patient herein represents that they have disclosed all pertinent information regarding their health profile to the provider of service during their examination. Patient further represents and guarantees that they have disclosed all medications they are currently consuming to this provider of service during their respective examination and from whom, if any, they are obtaining their medications.

This provider of service makes a determination based on full disclosure from the patient.

This provider of service reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination. This provider reserves the right to discontinue service at any time.

Should information be obtained that in any way suggests false representations were made to this provider of service by the patient; the patient forever waives any right to any claim made against this provider of service and this clinic.

The patient understands that if they lose their medications they will not be able to obtain a new supply until the next regularly schedule visit. Furthermore, medications cannot be exchanged, returned or credited under any circumstances. Patient also understands that if they go to another provider of service during the time frame of their treatment at this clinic, they are to notify this clinic and its representatives immediately of any other medications they might be receiving and that said notification must be executed in writing by and between this clinic and or its representative and the patient. The patient is also entitled to a copy of this notification after executed.

The patient has read and understands this release. The patient has also been explained to that this release constitutes a legal and binding document. A copy may be provided at the patient's request.

I □ **Do** / □ **Do not** request a copy. By not marking either box, it is implied that a copy is not requested

_____ Date _____

Patient Signature

_____ Date _____

Witness Signature

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Physical Exam

Patient Name:_____Date:_____ Age:_____

Height: _____inches / _____cm Weight: _____lbs Starting BMI: _____

Goal wt. (BMI 21-25):_____ Blood Pressure:_____/_____Pulse:_____ RR:_____

Exam:

HEENT: (NCAT)_____ Neck: (Thyroid normal) _____

Lungs: (CTA) _____ CV: (RRR no M) _____

Musculoskeletal: (Intact) _____ Neuro: (Intact) _____

Skin: (Normal) _____ Pysch: (Appropriate) _____

Plan (must be discussed with patient)

1) Diet: < 40-50 <70-80 Grams of Net carbohydrates per day over 4-5 small meals

2) Exercise: 1) continue current exercise regimen of: _____

2) low impact cardio/core training 3-4 X per week for 30-45 minutes

3) Medications: (Dosage, administration, precautions, and side effects must be discussed)

Injections: B12 (500 Mcg I.M. 1-2 /wk) B6 (50 mg I.M. 1/wk) Lipotropic 1-3 X / wk

Appetite Suppressant:

Dosage: PDZ: 35 Mg PHT 15 MG PDZ 105 MG PHT 30 MG PHT 37.5 MG

Frequency: ½ tab 1 tab 2 tabs qd bid tid (Please circle # of tabs and frequency)

Diuretic: HCTZ 25 mg Lasix 20 mg freq: 1X/wk 2X/wk Daily_ None_

_____ Notes:_____

Provider _____

_____