

## Patient Demographic Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F \_\_\_ M \_\_\_ Email: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Doctor Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred:  TV  INS  YP  RADIO  FRIEND  INTERNET  OTHER \_\_\_\_\_

**(DO NOT FILL OUT INSURANCE SECTION BELOW FOR WEIGHT LOSS OR AESTHETICS SERVICES)**

### INSURANCE INFORMATION

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Grp# \_\_\_\_\_ ID#: \_\_\_\_\_ Grp# \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.**

### ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Understanding Women and/or Thomas Laser Center for all services rendered. I hereby authorize Understanding Women and/or Thomas Laser Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

## Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee**. We will submit for the Physician and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

### **IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.**

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

***All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.***

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a \$40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a \$50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

**REFUNDS FOR AESTHETIC SERVICES:** All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

**PRODUCTS PURCHASES:** Products are Non-Refundable or Exchangeable.

**It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.**

**I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient's request.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

Patient Communication Authorization

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

\_\_\_\_\_ Home phone number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Mobile/Cell number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Work phone number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Call only this number. \_\_\_\_\_ Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

\_\_\_\_\_

\_\_\_\_\_ This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age \_\_\_\_\_ D.O.B: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Are you allergic to Latex:  Yes  No Hepatitis:  Yes  No HIV:  Yes  No

<u>Past Medical History</u>	<u>Past Surgical History/Year</u>	<u>Family History</u>	<u>Family Member</u> (Immediate)	<u>Current Medication/Vitamins</u> <u>Name/Dosage</u>
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> Heart Disease	_____	<u>SEE LIST</u>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> Long term steroid use	<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> GYN Cancer	_____	_____
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Surgery _____	<input type="checkbox"/> Blood clots in	_____	_____
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pace maker _____	lungs or legs	_____	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Defibrilator _____	<input type="checkbox"/> Colon/Bowel Cancer	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Prostate _____	<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Cholesterol disorder	<input type="checkbox"/> Bowel Surgery _____	<input type="checkbox"/> Prostate Cancer	_____	_____
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Tubal ligation _____	<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Thyroid Surgery _____	_____	_____	_____
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> C-section _____	_____	_____	_____
<input type="checkbox"/> Lupus/Autoimmune Dis	<input type="checkbox"/> Bariatric Surgery _____	_____	_____	_____
<input type="checkbox"/> Gout	<input type="checkbox"/> Cosmetic(type) _____	_____	_____	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	_____	_____	_____

**Social History:**

Other \_\_\_\_\_ Tobacco use:  Everyday  Some days  Former  Never

**Chief Complaint and Review of Systems**

- |   |  |
|---|--|
| <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Menopausal symptoms   |
| <input type="checkbox"/> Anal itch                | <input type="checkbox"/> Painful periods       |
| <input type="checkbox"/> Anal pain                | <input type="checkbox"/> PMS                   |
| <input type="checkbox"/> Anal warts               | <input type="checkbox"/> Rectal bleeding       |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Rectal drainage       |
| <input type="checkbox"/> Bladder control problems | <input type="checkbox"/> Screening Colonoscopy |
| <input type="checkbox"/> Breast mass/discharge    | <input type="checkbox"/> Unable to hold bowels |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Unable to hold gas    |
| <input type="checkbox"/> Fatigue/tired/sluggish   | <input type="checkbox"/> Vaginal discharge     |
| <input type="checkbox"/> Heavy vaginal bleeding   | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Hemorrhoids              | _____  |
|   | _____  |

**GYN History:**

- How many pregnancies: \_\_\_\_\_
- Are you pregnant: \_\_\_\_\_
- Do you plan to become pregnant: \_\_\_\_\_
- Are you breast feeding: \_\_\_\_\_
- Date of last:**
- Menstrual Period: \_\_\_\_\_
- Pap Smear: \_\_\_\_\_
- Abnormal Pap: \_\_\_\_\_ Result:  normal  abnormal  
Treatment:  burning  freezing  laser
- Colonoscopy: \_\_\_\_\_ Result:  normal  abnormal
- Pelvic US: \_\_\_\_\_ Result:  normal  abnormal
- Endometrial Biopsy: \_\_\_\_\_ Result:  normal  abnormal
- Bone Density Scan: \_\_\_\_\_ Result:  normal  abnormal
- Mammogram: \_\_\_\_\_ Result:  normal  abnormal

Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

HT: \_\_\_\_\_ WT: \_\_\_\_\_ HGB: \_\_\_\_\_

BP: \_\_\_\_\_ P: \_\_\_\_\_ PREG TEST: \_\_\_\_\_

## DIET HISTORY QUESTIONNAIRE

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_\_

How many years have you suffered with weight issues? \_\_\_\_\_  
Are you motivated for a weight loss program? YES / NO  
If so, how much weight do you want to lose? \_\_\_\_\_  
What size would you like to get back to? \_\_\_\_\_  
What is your starting weight? \_\_\_\_\_ Goal weight: \_\_\_\_\_ Height \_\_\_\_\_  
Can you forego eating out for 3 weeks? YES / NO  
What date would you like to begin the diet? \_\_\_\_\_  
Do you think you can do anything for 3 weeks? YES / NO  
Can you forego alcohol/beer/wine/spritzers, etc. for 3 weeks? YES / NO  
Do you or have you used laxatives? YES / NO  
Have you been dieting or restricting calories? \_\_\_\_\_  
If so, how long? \_\_\_\_\_  
Prior use of HCG? YES / NO If so, how long ago? \_\_\_\_\_  
How much did you lose using HCG? \_\_\_\_\_ Did you complete the program? YES / NO  
What other diets have you tried? \_\_\_\_\_  
When was the last time? \_\_\_\_\_  
Why did they fail? \_\_\_\_\_  
Do you yo-yo diet? \_\_\_\_\_  
How many times a week do you eat fast food? \_\_\_\_\_  
How many sodas do you drink in a day? \_\_\_\_\_  
How much alcohol do you consume in a week? \_\_\_\_\_  
What is your weakness, chips/snack foods or sweets? \_\_\_\_\_  
What is your comfort food? \_\_\_\_\_  
Are you a vegetarian or vegan? YES / NO  
Do you have any special dietary requirements? \_\_\_\_\_  
Do you exercise? YES / NO If so, how often and what form of exercise do you enjoy?  
\_\_\_\_\_  
If not, why? \_\_\_\_\_  
Are your family/friends supportive OR do they try to sabotage your efforts? \_\_\_\_\_  
\_\_\_\_\_  
What do you do for entertainment? \_\_\_\_\_  
\_\_\_\_\_  
Do you have a buddy or colleague or group of people that you can do this with? It's much easier if you do this with someone else and have a support system. YES / NO

### COMMITMENT CLAUSE

**DO NOT DO THIS PROGRAM IF...you are just going to treat this as if it is a fad diet.** This is not another diet fad. The only reason this works is the HCG...period. If you try the Fat Burning Food Plan (FBFP) WITHOUT HCG, you will have the shakes and be faint and famished within 3 days. With the HCG, you body consumes the excess fat for food and you rarely get the shakes, feel faint or feel famished (until you get immunity or lose ALL excess fat). You may feel hungry as you stomach shrinks. You can then eat a tomato or a cucumber or an apple or an orange. This may delay the goal weight by a day (maybe, maybe not), but at least you are eating healthy, approved foods.

**DO NOT DO THIS PROGRAM IF...you are not going to do it at least 21 days or travel frequently.** IF you don't do this diet for 21 days, you hypothalamus is NOT reset and you will just gain back all the weight. Your body won't keep track of the fat storage until after 21 days.

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_\_

**DO NOT DO THIS PROGRAM IF...you think you can just try it out and see if it works for you.** You have to be committed to this. It isn't easy. It is harder than other diets because it takes a commitment to both eat exactly as the method dictates AND take the medicine. What is easy about this diet, is the weight loss. If you follow the rules AND take you HCG, the pounds come off and stay off.

**DO NOT DO THIS PROGRAM IF...you are not going to be completely dedicated to following the VERY STRICT rules.** I can't say this enough - NO, you can't eat carbs (other than the melba toast). NO, you can't keep drinking regular soda. NO, you **CANNOT** substitute your favorite (steak, vegetable, fruit, beverage, seasoning) for the items on the allowed list. If you do this protocol half heartedly and with no commitment, you not only WILL fail, but since you failed, everyone around you watching with hope, will think this doesn't work, when in truth it was you, who by not following the protocol, didn't work.

**DO NOT DO THIS PROGRAM IF...you don't believe you can survive on restricted caloric intake, no matter how heavy you are to start out.** Some people think, "Well I am bigger," or "I require more food than the average person." Well, you are wrong. All the food you need is around you waist. The bigger you are, the more you have. The more you need, the more is available - right there, around your waist. The FBFP is meant to give you protein for muscles and quick energy for your brain and also keeps your normal fat stores topped off. Just as the daily dose of HCG is the same in all cases, so the same diet proves to be satisfactory for a small elderly person of leisure or a hard working muscular giant. Under the effect of HCG the body is always able to obtain all the calories it needs from the abnormal fat deposits, regardless of whether it uses up 1500 or 4000 per day. It must be made very clear to you that you are living to a far greater extent on the fat which you are metabolizing than on what you eat.

**HINT:** Green tea and fiber are natural appetite suppressants.

I have read the above and understand what this medical program is asking me to do and I am willing to do it 110%.

I agree to follow the diet strictly and take the HCG twice daily. If I cheat I will document it. I WILL NOT SUBSTITUTE ANY OF FOODS NOT ON APPROVED LIST.

I am not being coerced into doing this by anybody.

I agree to commit to this program for a minimum of 6 weeks and take it seriously.

I agree to weigh every day.

I agree to come for follow-up every 3 weeks

I agree to return every 3-4 weeks for follow-up and photos. The photographs, videos, and tapes shall be the property of Keri Sweeten, M.D., and may be used for teaching, publication or scientific research purposes. Your identity will not be revealed unless we expressly get your permission.

Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



## Informed Consent

**Sublingual HCG** (Human Chorionic Gonadotropin) is a prescription medication used by Dr. Sweeten in her weight loss program.

**With any drug there is the possibility of an allergic reaction or unusual reaction that may cause skin rash, difficulty breathing and other side effects, although rare.**

**HCG** There may be some side effects to the HCG. The most commonly experienced are: tenderness of the breasts, disruption in menstrual cycles (i.e. early onset or delayed - usually one week) or breakthrough bleeding. It does not, however, interfere with the effectiveness of your contraception or birth control. Other possibilities not generally seen which may occur in male patients are tenderness in the groin.

Possible adverse reactions which may rarely occur include headache, irritability, restlessness, depression, fatigue, edema. Hypersensitivity is extremely rare. **Caution: If you are pregnant and/or will be nursing an infant DO NOT take this medication.**

**HCG** is virtually free of negative side effects, but because you must follow a very low calorie, low fat diet that can sometimes trigger a gallbladder attack in individuals who are genetically pre-disposed to gallbladder disease.

Your medication will be discontinued if there is an adverse reaction.

I understand that the program and medications may involve risk. I understand that there are no refunds, returns or store credit for medication and that there is no weight loss guarantee with our program. I have read and understand the information given to me about the medications. I have asked and had answered any questions that I may have after reading this form. I understand the possible side-effects and agree to advise KERISMA Centre for Medical Weight Loss if this should occur. I understand that I may quit the program at any time. I agree to stop the **HCG** if I become pregnant and agree to advise KERISMA Centre for Medical Weight Loss should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact KERISMA Centre for Medical Weight Loss. If I experience an emergency situation, I understand that I need to go to an emergency facility. I authorize KERISMA Centre for Medical Aesthetics to use my photos for advertising purposes as needed.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY UNDERSTANDING WOMEN OR KERISMA CENTRE FOR MEDICAL WEIGHT LOSS OF ANY CHANGE IN YOUR HEALTH STATUS.**

\_\_\_\_\_  
Patient's Name (PLEASE PRINT)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

## MEDICATION ADVISORY FORM FOR APPETITE SUPPRESSANTS

The staff at UNDERSTANDING WOMEN and KERISMA Centre for Medical Weight Loss *hopes your experience with us will be pleasant as well as rewarding.* To ensure your experience with us is a pleasant, we want you to be aware there are several side effects and/or reactions to appetite suppressants. There is a possibility you may not experience any of these listed, however, the most typical or more commonly experienced side effects with using suppressants are:

dryness of mouth	unpleasant	occasional headaches
diarrhea and/or constipation	sleeplessness	

### POSSIBLE SIDE EFFECTS

**Appetite Suppressants:** The medication may cause restlessness, dizziness, tremors, headaches, and/or depression. When taken as prescribed there are rarely any psychotic episodes. In some cases a patient may experience blood pressure elevation, rapid heartbeat and/or pounding in the chest. The less common, but possible risks are: primary pulmonary hypertension and valvular heart disease. Do not take if you have cardiopulmonary disease. These and other possible risks could be serious or fatal. Important; Doctors and Anesthesiologist require different lengths of time off different medications prior to surgery. We recommend that if you anticipate surgery in the near future do not go on this diet until you have recovered and been cleared by you surgeon. In order to avoid any possible delay in surgery, notify us before going off all medication from UNDERSTANDING WOMEN or KERISMA Centre for Medical Weight Loss at least two weeks before your surgical date.

**How to Use This Medication:** Follow the directions for using this medicine. This medication may be taken with food. Cautions; When taking this medicine alone or with other medicine(s) and/or alcohol, it may affect your ability to drive and/or operate equipment, or perform other potentially dangerous tasks. Until you are aware of how this medication affects your Central Nervous System, avoid activities that require alertness and/or good Psychomotor coordination. **BEFORE YOU BEGIN TAKING ANY NEW MEDICINE** either prescription or over-the-counter, check with your Doctor or Pharmacist. If you are pregnant and/or will be nursing an infant **DO NOT** use this medication.

PLEASE DO NOT WAIT until your next visit to report these or any other side effects you may be experiencing to our nursing staff. Due to a wide variety of choices with selecting both the medication and strength, we can almost always help you become more comfortable.

I have carefully read and fully understand all the above information, and acknowledge the possibility of all risks with using the medications in this program. I therefore assume all risks, and hold Understanding Women, KERISMA Centre for Medical Weight Loss, and the provider(s), harmless to any, and/or all, reactions or side-effects experienced while taking any, and/or all, of said medications.

Each Patient will only be allowed one bottle (15 pills) of appetite suppressants per round of diet. The dosage is a half a pill per day. Refills will be not be given under any circumstances. **Int.**\_\_\_\_\_

Patient's legal name \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

\*The information contained in this advisory form is not intended to cover all possible uses, directions, precautions, drug interactions and/or adverse effects. This information is generalized and is not intended as specific medical advice.