ATLANTA MEDICAL INSTITUTE EVALUATION FORM

Patient's Name: _____ DOB: _____ Date: _____

Please check which apply (current or past history)

HEAD/EARS

___Ear Aches

___Ear Infections

___Ear Irritation

___Ringing In Ears

___Headaches

___Migraines

NOSE/SINUS

___Runny Nose

___Frequent Sneezing

___Wheezing

___Chronic Cough

___Sinus Congestion

___Chest Congestion

___Seasonal Allergies

EYES/THROAT

___Itchy Eyes / Dry Eyes

___Watery Eyes

___Sore Throat

___Canker Sores

SKIN

___Eczema/Psoriasis

___Dermatitis

___Rash/Hives

___Dry Skin

___Excessive sweating

___Acne

MUSCULOSKELETAL

___Joint Pain

___Arthritis/Tendonitis

___Muscle Aches

CARDIO-VASCULAR

___Chest Pain

___Shortness of Breath

___Heart Palpitations

___Rapid Heartrate

___Irregular Heartrate

___High Cholesterol

___Varicose Veins

___Swelling in Limbs

___Pain in Arms/Legs

___Fatigue and Myalgia

___Resting pain/claudication

___Color changes to skin

___Cold hand or feet

___Ulcers/sores that do not heal

___Motor Deficiency

___Hair Loss

___Numbness/Tingling legs/feet

___Lower extremity pain/weakness

___Leg or foot cramps

WEIGHT

___Obesity

___Unexplained Weight Gain

___Inability to Lose Weight

___Abdominal Fat

___Food Cravings

ENERGY

___Fatigue

___Hyperactivity

___Restlessness

___Difficulty Sleeping

DIGESTION

___Reflux/Heartburn

___Bloating/Gas

___Nausea / Vomiting

___Stomach Pain/Cramping

___Constipation/Diarrhea

___ Adverse Food Reaction

___ GI Upset from Foods

___Irritable Bowel Syndrome

___Lactose Intolerance

___Gluten Intolerance

EMOTIONAL/MENTAL

___Depression

___Anxiety

___Irritability

___Mood Swings

___Poor Memory

GENITO-URINARY

___Bladder Irritation/Pain

___Frequent UTI

___Yeast Infection

___Increased Frequency Urination

___Blood in Urine

OTHER SYMPTOMS

___Thyroid Issues

___High Blood Pressure

___Blood Sugar Control

___Libido Issues

___Declined Intimacy

__Abnormal Menstrual Cycle

___Inability/Premature Ejaculation

___Erectile Dysfunction

Allergies: _____

Current Medications/Dosage/Indications:

_____
_____
_____
_____
_____
_____
_____
_____

Medical History: Please check if applicable:

☐ Hypertension	☐ Diabetes	☐ Blood clots	☐ Chest pain
☐ Heart attack	☐ TIA	☐ Heart murmur	☐ Circulatory disease
☐ Stroke	☐ Deep Vein Thrombosis	☐ Pulmonary Embolism	☐ Feet swelling
☐ Frequent headaches	☐ Constipation	☐ Glaucoma	☐ Kidney disease
☐ Autoimmune disease	☐ Pregnant/Breastfeeding	☐ HIV/AIDS	☐ Hepatitis B/C
☐Sedentary	☐Age greater than 50	☐Emphysema	☐Thoracic Outlet Syndrome
☐Smoking	☐Obesity	☐Varicose Vein	☐Previous Vascular Surgery

Surgeries/Hospitalization/Year:

_____
_____
_____
_____

Family History:
Mother: ☐HPN ☐Diabetes ☐Cancer ☐Heart Disease ☐Stroke ☐Autoimmune Disease
Father: ☐HPN ☐Diabetes ☐Cancer ☐Heart Disease ☐Stroke ☐Autoimmune Disease
Siblings: ☐HPN ☐Diabetes ☐Cancer ☐Heart Disease ☐Stroke ☐Autoimmune Disease
Maternal Grandmother: _____ **Paternal Grandmother**: _____
Maternal Grandfather: _____ **Paternal Grandfather:** _____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoking: ☐ Never ☐ Quit _____packs _____years
Alcohol: ☐ Never ☐ Quit ☐ Occasional ☐ Social ☐ Regular ☐ Heavy
Coffee/Tea: _____ cups / day **Stress level**: ☐ High ☐ Low ☐ None
Occupation: _____
OB-Gyn History:
Last menstrual period: _____ ☐ Regular ☐ Irregular ☐ Menopause ☐ Hysterectomy
Type of Contraception: _____ Hormone Replacement Therapy: Y/N
Last visit to a PCP: _____
Last PAP test: _____ Mammogram: _____ Colonoscopy: _____
Nutrition Evaluation:
What is your weight goal: _____ By when: _____ Reason: _____
What was your weight one year ago: _____ Your heaviest weight: _____
How often do you eat out: _____ Which Restaurants: _____
Do you crave for: sweets/ salt Time of day: _____ What month: _____
Do you use sugar substitute: Y/N Butter: Y/N Margarine: Y/N Midnight snacks: Y/N
Do you eat more under stress: Y/N

Patient Information Form

Name: (Last) _____ (First)_____(MI) _____

Name you prefer to be called: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Patient Address for shipping: (No PO Boxes) _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail: _____

Birthdate: _____ SS #: _____ Age: _____ Sex: M F

How did you hear about us? (Circle)

Sign Internet Coupon Referral Event Direct Mail TV Other:

_____

Employment Information:

Patient Employer: _____ Occupation: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip:

_____

In Case of Emergency:

Name: _____(Relationship)_____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____

Financial Policy Agreement:
Thank you for selecting Atlanta Medical Institute (AMI) for your health care needs. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.
For your convenience, we accept Visa, MasterCard, American Express and Care Credit.

By signing this Financial Policy Agreement, I agree:

1. **My AMI Weight Loss Program is non-refundable!** Any program credit can be used for any service AMI offers.

2. A 30% administrative fee will be applied to any approved refunds, decided at the sole discretion of our medical director. 3. I will be responsible for all collection costs, attorney's fees and court costs if applicable.

4. I have read and understand all of the above and have agreed to these statements.

Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCOLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Atlanta Medical Center (AMI) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to AMI's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NPP) prior to signing this consent. AMI reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to AMI. With my consent, AMI may:

- call my home (or other location) and leave a message on voice mail or in person in reference to any item(s) that assist the practice in carrying out TPO, such as:
    - appointment reminders
    - insurance items
    - calls pertaining to my clinical care (including laboratory results among others)
- mail to my home (or other location) any items that assist the practice in carrying out TPO, such as:
    - appointment reminder cards
    - patient statements as long as they are marked Personal and Confidential
- email to my home (or other location) any items that assist the practice in carrying out TPO, such as:
    - appointment reminder cards and patient statements

By signing this form, I am consenting to AMI's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AMI may decline to provide treatment to me.

I have been offered and have had the opportunity to review the HIPAA disclosure form: _____

_____
Signature of Patient

_____ Date _____
Patient Name

REQUEST TO RELEASE MEDICAL RECORDS

I request the release of my medical records from Atlanta Medical Center (AMI) to _____. I release AMI, its managers, physicians, and contractors from any and all claims resulting from this release, as I realize these constitute their permanent records. I authorize each physician, doctor, nurse, clinic, or and other health care provider to provide any and all information or records as to diagnosis, treatment or prognosis concerning my past, present or future physical or mental history or condition for Date: 2017.

I acknowledge and understand that I may revoke this authorization at any time by notifying AMI of my revocation in writing and delivering my revocation by mail or personal delivery. I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser on my behalf may be disclosed and may no longer be protected by the HIPPA Privacy Regulations. I certify I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I request these medical records be forwarded as follows:

Fax: _____Email: _____

_____ _____ _____

Patient Signature Name (Print) Date

Patient Informed Consent for Appetite Suppressants & Weight Loss Programs

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Atlanta Medical Institute (AMI) 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 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 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 over weight 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. I understand that there are no refunds available on any of the products I am taking. If I am not satisfied with these medications, I will discontinue using them.

Medications are non-returnable or refundable in any part.

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.
- If any provision in this agreement is found to be unenforceable, such finding does not invalidate the entire agreement, but only that particular provision.
- I hereby grant AMI permission to use my photograph in any and all publications, including web site entries, without payment or any other consideration in perpetuity.
- I hereby authorize AMI to edit, alter, copy, exhibit publish or distribute this folder. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my photo appears. Additionally, I waive the right to royalties or other compensation arising or related to the use of the photography.
- I hereby hold harmless and release and forever discharge AMI from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate which may have or may have or may have by reason of this authorization.
- I hereby grant AMI to send solicitation and promotional communication via phone, text and email.
- I understand I can have my prescription filled at any pharmacy of my choice.
- I am 18 years of age or older and am competent to contract in my own name. I have read this release, and fully understand the contents, meanings, and impact of this release.

PATIENT SIGNATURE (weight loss): _____ Date: _____

PATIENT SIGNATURE (Phentermine) _____ Date: _____

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 **Date**

Consent for Human Chorionic Gonadotropin (hCG) Anti-Aging/Weight-Loss Program

I request and consent to injections and sub-lingual use of hCG and strict dietary restrictions for the purpose of losing weight. I understand this will be administered and monitored by the medical providers with Atlanta Medical Center (AMI). I u0nderstand that as part of the program I will be given a limited physical and orientation to the program, will be instructed on how to administer the injections myself or make arrangements to have someone do so. I understand that initial blood tests will be performed to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to report any problems that might occur to the medical provider during the treatment program immediately. I further understand that there could be risks involved as there are with all medications and that not complying with the dosage recommendations and dietary restrictions could increase risks and alter the results. Product information is available upon request. The usage guidelines noted in the product information are consistent with a10 - 15,000 unit's dosage per week.

I understand that hCG is not FDA approved for weight loss. I also understand that there is medical evidence to support use of hCG for this purpose. The medical providers with AMI provide the treatment with hCG. I agree that I am, and will be under the care of another medical provider for all other conditions. AMI works in conjunction with, but cannot replace, regular primary care physicians, such as general practitioners or other specialists in Family Medicine or Internal Medicine. hCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets. I understand the medical providers with AMI only prescribe hCG and medication necessary for this treatment with hCG only as part of the weight loss program. The providers with AMI will not prescribe any other type of prescription or non-prescription medications of any kind that fall outside of weight loss or hormone therapy. We are sometimes asked by patients to provide or renew other medications (such as painkillers or anti-depressants), which were originally ordered by other medical providers. We are not able to comply with such requests because it may lead to confusion and substandard medical care. Because we are committed to enabling our patients to obtain and maintain health and wellness naturally, and the services provided by our office are based upon a natural and preventative approach, it is rare that this program is covered by insurance companies. Weight loss, in general, is rarely covered by insurance companies. For this reason, we do not accept or bill insurance for this program. Once labs are done, the physical is performed, and the treatment is started, we cannot honor any refund requests based on scheduling conflicts, missed doses, unsatisfactory results, etc.

The initial blood test will be covered by the plan fee and will be conducted by a licensed lab.

I have read and understand all of the above and have been informed of potential side effects and risks that may be associated with the hCG protocol. I fully understand what I am signing and hereby request and consent to anti-aging/weight-loss treatment using injections of hCG. I understand that results may vary and once I have begun the protocol I am committed to seeing it through.

Patient Signature: _____ Date: _____