Patient Information Form

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

Name you prefer to be called: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Best daytime phone: _____ May we leave a message there? Yes No

Alternate phone number: _____ May we leave a message there? Yes No

Birth date: _____ Age: _____Sex: M F

Highest grade of school completed: _____ Occupation_____

Social Security # _____Driver's License # _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Social History:

Marital status(circle one)Single*Married*Divorced*Separated * Widowed * Live with significant other

Do you smoke? Yes No How much per day? _____

Do you drink alcohol? Yes No How much per week?_____

List all medications currently prescribed for you, indicate prescribing physician and whether you're taking them as prescribed or not: (note: this **must** match your pharmacy's med list)

Your Past Medical History:

Circle any conditions you have been treated for in the past:

High blood pressure	Heart attack	Chest Pain	Stroke
Diabetes	Obesity	Digestive problem	Lung problem
Other heart problem	Psychiatric problem	Muscle problem	Bone problem
Kidney/bladder problem	Skin problem	Thyroid problem	Alcohol dependence
Drug dependence	Eating disorder	Seizures	

Other: (specify) _____

Review of Systems:

Any problem today with: Breathing, chest pain or palpitations, movement, stomach upset, nerves?_____

_____

FEMALES ONLY: Do you believe you may be pregnant? Yes No

Family History:

Has any of your immediate family had problems with anything listed under past medical history (above)? If so, list. _____

Is anyone in your immediate family overweight? Who?_____

Patient Initials:_____

Nutrition/weight loss History:

Height _____ Present weight _____ Desired weight _____

Birth weight _____ Weight at 20 years old _____ Weight one year ago _____

Maximum lifetime weight (non-pregnant) _____

What caused you to gain weight in the first place?_____

Previous diet programs: (list) **Amount lost** **Year** **Physician** (if medications used)

Food allergies: _____

Food dislikes: _____

Foods craved: _____ When?_____

Do you drink diet drinks/eat diet foods or use artificial sweeteners? Yes No

What are your worst food habits?

What have you done to try to change that?

Typical breakfast: **Typical lunch:** **Typical dinner:**

_____ _____ _____

_____ _____ _____

Snack habits: What?_____ When?_____ How much? _____

When you're under stress, do you: Eat more Eat less

Your energy level is generally: high medium low

Your job is: physically hard medium easy

Your job is: high stress medium stress low stress

Rate your behavior style: _____ (1=usually calm, very laid back 3=very hard-driving, seldom relaxed)

Your most important reason to lose weight is: _____

* * * * *

Patient Initials:_____

FINANCIAL POLICY DISCLOSURE & PATIENT CONSENT

This is to inform you of our billing requirements and financial policy at Mackey Clinic, LLC. **Please be advised that payment for all services will be due at the time services are rendered**. For your convenience, we accept cash, Visa, MasterCard, Care Credit, and Debit Cards.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs.

I have read and understand the above financial policy and hereby agree and consent to these statements.

_____ _____

Patient's Signature (or person authorized to consent for patient) Date

* * * * *

INFORMED PATIENT WEIGHT LOSS PROGRAM & APPETITE SUPPRESSANT CONSENT

I, _____, authorize Dr. Mackey and whomever she designates as her assistants, to treat and assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. 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 FURTHER UNDERSTAND THAT ANY MEDICAL TREATMENT INVOLVES RISKS AS WELL AS 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, fatigue, 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, 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 MY 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. I have read and fully understand this consent form and realize 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 been given all the time I need to read and understand this form.

I HEREBY AUTHORIZE Dr. Mackey to assist me in my weight reduction efforts. I understand that my treatment may involve, but is not 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.

I have read and understand my doctor's statements that follow:

> "Medications, including appetite suppressants, have labeling approved by the makers and the Food and Drug Administration. This labeling contains, among other items, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (12 weeks or less) using doses indicated on the labeling.

Patient Initials:_____

As a bariatric 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 research. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time, and at times, in increased dosages. Such usage has not been as systematically studied as that suggested in the labeling and it is possible that there could be serious side effects, as noted below.

As a bariatric 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 dosages. 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 provide."

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. I further 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. 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.

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 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.

Date: _____ **Date:** _____

Patient:_____ **Witness:**_____
(or person with authority to consent for patient**)**

PHYSICIAN DECLARATION:

I have answered all the patient's 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 possibly involving the appetite suppressants in the manner indicated above.

_____ _____
Physician's Signature **Date**

Patient Initials:_____

MEDICATION AGREEMENT

As part of my weight reduction treatment, the use of appetite suppressants and other medications may be part of my program. In the event that appetite suppressants and/or medications are prescribed to me, I hereby agree to the following:

1. I will take the medication only as prescribed.
2. I understand that the medication will be prescribed only by Dr. Mackey and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.
3. I will not seek or accept any medications for weight loss or appetite suppression other than those prescribed by my doctor.
4. Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working day's notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.
5. I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.
6. I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen controlled substance or controlled substance prescriptions.
7. I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made.

In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any weight loss or appetite suppression medication from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescriptions only at the pharmacy I list below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office may provide my chosen pharmacy with a copy of this agreement.

Patient Initials:_____

Pharmacy name_____

Pharmacy address_____

_____

Pharmacy telephone_____

Medication name, dose and directions _____

Number of pills prescribed _____Frequency of appointments _____days

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

_____	___/___/___	_____	___/___/___
Patient signature	Date	Physician signature	Date

Patient Initials:_____