Memorial Weight Loss Clinic
1458 Campbell Rd Ste150 Houston, TX 77055 Ph:713-468-3322

Medical History Questionnaire

First/Last Name	DOB: Age: Male/Female:
Address:	Home Phone: Cell Phone:
City/State/Zip Code:	Email Address:

How did you hear about our clinic: _____

Check the factors that pertain to you

Inactivity___Overeating___Sedentary Job___Injury___Childbirth___Stress___Depression___Smoker___

Drink Alcohol___

Other/Explain _____

Medical History

Asthma___Cervical Cancer___Depression___Bi-polar Disorder___Diabetes___Hypertension___

Infertility___Menopause___Anxiety___Obesity___Thyroid Problems___ Cholestrol__

Other/Explain briefly_____

Surgical History

Back Surgery___Breast Augmentation___C-Section___Gall Bladder___Gastric Stapling/Bypass/Lap Band___

Hernia___Hysterectomy___Laparoscopy___Liposuction___Thyroid Removal___Tubal ligation___

Other/Explain _____

Family History

Cancer___Depression___Diabetes___Heart Disease___Obesity___Hypertension___Stroke___

Other/Explain _____

Is there a certain diet that you follow? Explain.

_____

Do you exercise? Specify.

_____

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Are you currently taking any medication? If yes, please list medication and dosage.

_____

Are you allergic to any medication? YES/NO

_____

If so, please specify:_____

Are you breastfeeding? YES/NO

When was your last menstrual cycle? _____

Do you have a heavy menstrual cycle? YES/NO

Do you have any uterine fibroids? YES/NO

Do you have any cobalt allergies? YES/NO

Do you have glaucoma? YES/NO

Name of pharmacy/ Number_____

****Note to Patient: During the course of your treatment at Memorial Weight Loss Clinic it is critical that you keep our staff up to date on any changes in your medication. Please inform us immediately if you start a new medication or change a current one. Please sign here indicating you have read this:**

_____

Patient Signature

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Patient Informed Consent for Appetite Suppressants

Procedure & Alternatives:

I, _____, authorize Memorial Weight Loss Clinic (MWLC) 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 6 months and when indicated in higher doses than the dose indicated on the appetite suppressant labeling.

I have read and understand MWLCs statements that follow:

- Medications, including 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 6 months) using the dosage indicated in the labeling.

- Such usage has not been as systematically studied as suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

I understand it is my responsibility to follow the instructions carefully and to report to MWLC any significant medical problems that I think may be related to my weight control program as soon as possible. I understand the purpose of this treatment is to assist me in my desire to lose weight and to maintain the 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 lose weight and to maintain the weight loss. In particular, a balanced calories counting program or and 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.

Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 6 months and in higher doses than the dose indicated in the labeling involves some risks. The more common side effects include nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and alveolar heart disease. These and other possible risks could, on occasion, be serious or fatal.

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 hypertension and diabetes, to heart attack and heart disease, and to arthritis of the joints, hip, knee, and feet. I understand these risks may be modest if I am not very overweight but that these risks can go up significantly the more overweight I am.

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 maintain my weight all of my life if I am to be successful.

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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 necessary in reading and understanding this form and in talking with MWLC regarding other treatments not involving the appetite suppressants.

Warning!

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, PLEASE ASK BEFORE SIGNING THIS CONSENT FORM.

_____ _____

Patient Signature Date

MWLC PROVIDER DECLARATION:

I have explained the consents 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 if the appetite suppressants, the benefits and risks associated with alternative therapies and the risks for continuing in an overweight state. After being adequately informed, the patient as consented to therapy involving the appetite suppressants in the manner indicated above.

_____

MWLC Provider Signature

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Weight Loss Program Consent Form

I, _____, authorize Memorial Weight Loss Clinic and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, regular exercise program, instruction in behavior modification techniques; and may involve a very low calorie diet, or a protein supplemented diet. 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 practices, as well as in academic centers for periods exceeding those recommended in the product literature. I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risk of this program, may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, 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 over weight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints hips, knees, feet, and back, sleep apnea, and sudden death. I understand that much of these risks may be modest if I am not significantly overweight, but will increase with additional weight gain. I understand that much of this 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 obesity may be a chronic, life-long conditions at may require changes in eating habits and permanent changes in behavior to be treated successfully. 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 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.

IF YOUR LAB WORK IS TESTED ABNORMAL, MEMORIAL WEIGHT LOSS CLINIC WILL RECOMMEND YOU STOP TAKING THE MEDICATION UNTILL YOU CONSULT WITH YOUR PRIMARY CARE PHYSICIAN. WE ARE NOT HELD RESPONSIBLE IF YOUR LAB WORK IS TESTED ABNORMAL, WE HAVE PROVIDED OUR SERVICES 100%, THEREFORE, THERE ARE NO REFUNDS!

_____ _____

Patient Signature Date

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Consent for Human Chorionic Gonadotrophin (HCG) Weight Loss Program

I _____, request and consent to injections of HCG and strict dietary restrictions for the purpose of losing weight. I understand this will be administered and monitored by the medical providers at Memorial Weight Loss Clinic. I understand that as part of the program I will be given a limited physical and orientation to the program, and I will be instructed on how to administer the injections myself or make arrangements to have someone do so. I understand that initial blood tests may be performed to rule out any conditions that would disqualify me from the program or require any prior treatment program. 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 a 10-15,000 units dosage per week. The Simeons's protocol calls for only 900 units dosage per week. There are currently no studies available at this dosage outlining possible risks.

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 at Memorial Weight Loss Clinic provide and administer the treatment with HCG. I agree that I am, and will be under the care of another medical provider for all other conditions. Our clinic 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 it 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 at Memorial Weight Loss Clinic only prescribe HCG and medication necessary for this treatment with HCG as part of the weight loss program. The providers at Memorial Weight Loss will not prescribe any other type of prescription or non-prescription medications of any kind.

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 treatment is started, we cannot honor any refund requests based on scheduling conflicts, missed doses, unsatisfactory results, etc.

If blood work is indicated, the test will be conducted by a licensed lab and the fee added to your initial visit fee.

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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.

I understand that results may vary and once I have begun protocol I am committed to seeing it through.

Patient Name (printed):_____

DOB: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell Phone: _____

_____ _____

Patient Signature Date

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Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Effective Date of the Notice: 1 March 2011

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintain the privacy of your personal health information (PHI). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

1. How we may use and disclose your PHI.

2. Your privacy rights in your PHI.

3. Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

1. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

2. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (iv) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to PHI of the decedents.

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3. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.

4. Military. Our practice may disclose your PHI if you are a member of the U. S. or foreign military forces (including veterans) and if required by the appropriate authorities.

5. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to other official or foreign heads of state or to conduct investigations.

6. **Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate.

WE MAY USE AND DISCLOSE YOUR PRIVATE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:
The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your PHI to bill you directly for services and items benefits, and we may provide your insurer with details regarding your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as PHI to federal officials in order to conduct an investigation or to enforcement officials if you are an inmate.

3. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs as family members. Also we may use your PHI to bill you directly for services and items

4. Health Care Operations. Our practice may use and disclose your PHI to operate our business. We may use and disclose your information for our operations to

YOUR RIGHTS REGARDING YOUR PHI:
You have the following rights regarding your PHI that we maintain:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home rather than work. To request a type of confidential

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communication you must make a written request to Office Manager, Memorial Weight Loss Clinic 1458 Campbell Rd St 150 Houston, TX 77055 specifying the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your PHI to certain individuals involved in you care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI you must your request in writing to Office Manager, Memorial Weight Loss Clinic 1458 Campbell Rd St 150 Houston, TX 77055. Your request must describe in a clear and concise fashion:

a. the information you wish restricted;

b. whether you are requesting to limit our practice's use, disclosure or both; and to a communicable disease

c. to whom you want the limits to apply

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Office Manager, Memorial Weight Loss Clinic 1458 Campbell Rd St 150 Houston, TX 77055 in order to inspect and/or obtain a copy of you PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. **Treatment Options**. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services**. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends**. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example a babysitter may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example a babysitter may have access to this child's relevant medical information.

8. **Disclosures Required By Law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI.

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1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

a. Maintaining vital records, such as births and deaths
b. Reporting child abuse or neglect
c. Preventing or controlling disease, injury or disability
d. Notifying a person regarding potential exposure to a communicable disease
e. Notifying a person regarding a potential risk for spreading or contracting a disease or condition
f. Reporting reactions to medications or problems with medical products or devices
g. Notifying individuals if a product or medical device they may be using has been recalled request to inspect and/or copy in certain limited circumstances. You may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

2. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Office Manager, Memorial Weight Loss Clinic 1458 Campbell Rd St 150 Houston, TX 77055. You must provide us with a reason that supports your request for an amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. We may deny your request if you ask us to amend information that is in our opinion is: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of PHI which you would be permitted to inspect and copy; or (d) not created by our practice unless the individual or entity who created the information is not available to amend the information.

3. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, a doctor may share information with the nurse; or the billing department may use your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Office Manager, Memorial Weight Loss Clinic 1458 Campbell Rd St 150 Houston, TX 77055. All requests for an "accounting of disclosures" must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before 1 March 2011. The first list you request with a 12-month period is free of charge but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with the additional requests, and you may withdraw your request before you incur any costs.

4. Abuse or Neglect. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to do so.

5. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

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6. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

7. Law Enforcement. We may release PHI if asked to do so by a law enforcement official
   a. Regarding a crime victim in certain situations if we are unable to obtain the person's agreement
   b. Concerning a death we believe has resulted from criminal conduct
   c. Regarding criminal conduct at our office
   d. In response to a warrant, summons, court order, subpoena or similar legal process
   e. To identify/locate a suspect, material witness, fugitive or missing person
   f. In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

8. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary we also may release information in order for funeral directors to perform their jobs.

9. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact the Office Manager of Memorial Weight Loss Clinic at 713-468-3322.

10. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shannon at 713-417-2094 or at 668 Bunker Hill Rd. Houston, TX 77024. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

11. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization we will no longer use or disclose your PHI for the reasons described in the authorization. We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Shannon at 713-417-2094 or at 668 Bunker Hill Rd. Houston, TX 77024.

NOTICE TO PATIENTS
REGARDING PRESCRIPTION MONITORING PROGRAM

As of July 31, 2012 medical board investigators and physicians were granted Prescription Access in Texas II (PATII) on the web. This allows physicians to easily monitor the prescription history of a patient as part of a new process that the Texas Medical Board encourages physicians to go through in prescribing controlled substances. Specifically, this database allows the physician the real-time ability to query the prescriptions database and find out which controlled substances their patients have been prescribed by other practioners.

Using the new online database will help protect patients, the public, and the physician from many of the problems associated with prescribing controlled substances including the hazards of prescription drug diversion.

PLEASE NOTE THAT IS CONSIDERED A FELONY under Texas Health & Safety Statutes and Codes (2011) § 481.129 (a)(6) to omit information about what prescriptions you are currently or have been prescribed.

It is our protpcol here at the office of Babak Rejaie, MD PA, to query each and every patient that is given a prescription for a controlled substance.

I, _____, acknowledge that I have read this notice in its entirety and understand that if I am found to be falsely denying being issued a prescription for a controlled substance during the same time period by another practioner, Babak Rejaie, MD PA may take further action by turning the patient into law enforcement agencies.

_____ _____

Patient Signature Date