Beach
Medical Weight Loss

PATIENT BASIC INFORMATION FORM
(To be filled out by patient)

Name: Last _____ First _____ M.I. _____

Street Address: _____

City: _____ State_____ Zip _____

Phone Number: (_____)_____-_____ Cell Number: (_____)_____-_____

Birth date: _____ Current Age: _____ Sex: M F

E-mail address: _____@_____

How did you hear about us? (Please check all that apply)

___Radio
___Internet
___Television
___Mail-out
___Sign
___Newspaper
___Word of Mouth/Referred By: _____ (Please complete a referral card)

EMERGENCY CONTACTS
(At least 2 contacts)

Name: _____ Relationship: _____Phone: (_____)_____-_____

Name: _____ Relationship: _____Phone: (_____)_____-_____

Physician: _____ Phone: (_____)_____-_____

FINANCIAL POLICY

Thank you for selecting Beach Medical Weight Loss, LLC for your health care. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept Visa, MasterCard, Cash and Checks. I have read and understand all of the above and have agreed to these statements:

_____ _____
Patient's or Guardian's Signature **Date**

HIPPA PRIVACY NOTICE

I have received/reviewed a copy of the HIPAA privacy notice.

_____ _____
Patient or Guardian's Signature **Date**

LABS REQUIRED

I understand that I must have my labs drawn at the clinic or I must provide a copy of labs to Beach Medical that have complete test results for: Metabolic Panel, Lipid Panel, and Thyroid. Labs must be drawn or a copy must be submitted before you can receive a refill of your medication

_____ _____

Patient's (or Guardian's) Signature Date

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I.

I, _____ (patient or guardian name), understand and acknowledge that treatment by Beach Medical Weight Loss, LLC, Dr. Melissa Pearce, MD and their designated assistants is limited solely to assistance with weight reduction efforts. This treatment does not provide a substitute or replacement for any regular physician. Beach Medical Weight Loss, LLC and Dr. Melissa Pearce, MD does not treat acute or chronic medical problems, and I agree to see my regular physician for these problems.

II.

1. I, _____(patient or guardian name) authorize Dr. Melissa Pearce, MD and whomever he designates as his assistants 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. I understand that my program may consist of a balanced deficit diet, a regular exercise program, and instructions in behavior modification techniques, and may involve the use of appetite suppressant medications.
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 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 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 suppressant.

III.

1. RISKS OF PROPOSED TREATMENT:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than twelve 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 heartbeat 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. I understand that if I have questions or concerns about side effects or risks, or if I prefer to see the Medical Director (M.D.) for my evaluation and care, the Medical Director is available by appointment for these purposes.

2. NO GUARANTEE:

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 my life if I am to be successful in maintaining any weight loss achieved.

3. 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. I also understand that participation in this program is strictly voluntary and is my choice to participate or not. I understand that I may discontinue this treatment at any time at my discretion.

4. WARNING:

IF YOU HAVE ANY QUESTION AS TO 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 THE CONSENT SIGNATURE FORM.

I have read and fully understand this consent form. 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 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*.)

_____ _____

Patient or Guardian's Signature **Date**

PATIENT MEDICAL HISTORY

Full Name: _____ Age: _____ Sex: M F

Present Health Status:

1. Are you in good health at the present time, to the best of your knowledge? Yes No
   If "No", explain: _____

2. Are you under a doctor's care at the present time? Yes No
   If "Yes," explain.
   1._____
   2._____
   3._____

3. Are you taking any medications at the present time? Yes No

(Check box to note if medication is Prescription or Over the Counter)

Name of Medication	Prescription	Over the Counter	Dosage	Schedule
1.				
2.				
3.				
4.				
5.				
6.				

4. Any allergies to sulfa/sulfur type medications or any other medications? Yes No

Medication:	Reaction:
1.	
2.	
3.	

5. Do you have any of the following:

Diagnosis	Comments	Yes	No
High Blood Pressure			
Diabetes			
Seizures			
ADHD, Narcolepsy, or Sleep Apnea			
Heart Attack, Angina, or Chest Pain			
Hyper – or Hypothyroidism			
Glaucoma			
Mental Health/Psychiatric Diagnosis			
Use of Illicit or "Street" Drugs			
Addiction to Alcohol or Other Drugs			
Constipation			
OTHER			

Family History

6. Do you have a Parent or Sibling who has had:

Heart Attack/Stents/Bypass Surgery/Angina or Stroke **before age 55:** Yes No

What Family member? _____

At what age did they have their heart/stroke problems? _____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐ Gallbladder Disorder	☐ Drug Abuse	☐ Heart Valve Disorder	☐ Kidney Disorder
☐ Liver Disease	☐ Depression/Anxiety	☐ Heart Disease	☐ Anemia
☐ Ulcers	☐ Psychiatric Illness	☐ Lung Disease	☐ Bleeding Disorder
☐ Eating Disorder	☐ Alcohol Abuse	☐ Arthritis	☐ Thyroid Disease
☐ Liver Disease	☐ Gout	☐ Cancer	☐ Other

Do you have any other questions or concerns? Yes No

_____

_____

THIS IS A COMPLETE AND FULL DISCLOSURE AND SUMMARY OF MY MEDICAL HISTORY

_____ _____

Patient or Guardian's Signature **Date**

LIFESTYLE EVALUATION

Full Name: _____

GOALS

1. What is the main reason for your decision to lose weight? _____
2. What is your desired weight? _____ pounds
3. When would you like to be at this weight? _____ Date
4. How long ago did you begin gaining weight? _____ months/years
5. What do you think caused your weight gain? _____
6. What diets have you followed in the past and what were your results? Did you maintain your weight loss?
   Diet _____ Results _____ Maintained _____
   Diet _____ Results _____ Maintained _____
7. Food Allergies: _____

SOCIAL HISTORY

1. Do you drink coffee, caffeinated soft drinks, or tea? (Circle one) Yes No How much daily?_____
2. Do you drink alcohol? Yes No
   Daily? _____ Weekly? _____ Occasionally? _____
3. Do you smoke? Yes No
   If "Yes" how much? _____ packs per day
4. Do you exercise regularly?
   How many times per week? _____
   What type of exercise? _____

CONSENT TO TREATMENT

(WOMEN ONLY)

I understand that Phentermine and other anorectic medications should **NOT** be taken during pregnancy, due to the chance of adverse effects to the baby. The medications have been explained to me fully and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both Beach Medical Weight Loss, LLC *and* my OB/GYN immediately.

_____ _____

Patient or Guardian's Signature **Date**

_____ _____

Physician's Signature **Date**

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 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/Nurse Practitioner's Signature

DISCLOSURE AND CONSENT FORM

TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States. **NOTICE**: Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.

I voluntarily request that Dr. Melissa Pearce, MD and other affiliated health care personnel as he may deem necessary, treat my condition (or the condition of the person for whom I am responsible) as described below

I understand that some of, or all of, the following integrative and alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following: Administration of homeopathic remedies, herbal and nutritional therapies, off label use of pharmaceuticals, injectable vitamins and Amino Acids, B12 with or without Lipotropic, Choline, Methionine, Inositol, as well as:

I understand that no warranty or guarantee has been made regarding results of treatment. I realize that there may be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox reactions) and undesirable interactions between various treatments, both conventional and alternative, as well as:

I have been given an opportunity to ask questions about the treatment of this health condition using conventional, integrative and alternative methods. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment, and I believe that I have sufficient information to this informed consent. I certify this form has been fully explained to me, that I have read it (or have it read to me), that the blank spaces have been filled in, and that I understand its contents. I also certify that Dr. Melissa Pearce, MD has provided this Disclosure and Consent Form to me and fully explained the diagnostic and treatment options available and has made no guarantees to me as to the success of this treatment. I acknowledge that Dr. Melissa Pearce, MD has informed me that he functions only as an educator and consultant not as the primary care physician for any patient. I have assured him that I have another primary physician and do not/will not rely on Dr. Melissa Pearce, MD for that role.

SIGNATURE OF THE PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON REQUIRED BELOW:

_____	_____	_____
Patient or Guardian's Signature	**Print Name**	**Date**