Tucson Medical WEIGHT LOSS

New Patient Information

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____ Marital Status: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Home Number: _____

Email: _____

Employment Information:

Employer: _____ Occupation: _____ Work Number: _____

Emergency Contact:

Name: _____ Relationship: _____

Cell Number: _____ Work/Home Number: _____

Preferred Method of Contact:

With my permission, this establishment and all subsidiaries*, may contact me and leave voice mail messages in reference to any subject that assists in carrying out patient relations, such as, but not limited to: appointment reminders and laboratory results.

My preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

Patient or Legal Guardian's Signature: _____ Date: _____

How did you hear about our office? (Please be specific):

_____

What diet programs have you tried in the past? _____

What are your favorite radio stations? _____

What magazines do you read? _____

What news publications do you read? _____

Health issues, procedures, and/or products of interest to you: (Please check all that apply)

☐ Botox Cosmetic	☐ Retin-A	☐ Skin Rejuvenation	☐ Laser Resurfacing
☐ Juvederm/Radiesse Dermal Filler	☐ Microdermabrasion	☐ Hair Removal	☐ Acne
☐ Sun Damage/Age Spots	☐ Cellulite Reduction	☐ Spider Vein Treatment	☐ Skin Care Advice
☐ AHA, Glycolic or Chemical Peel	☐ Longer Eyelashes	☐ Removing Facial Veins	☐ Weight Loss
☐ Weight Loss Support	☐ Skin Care Products	☐ Facial & Eye Treatments	

☐ Other: _____

Would you like to receive emails from Tucson Medical Weight Loss? ☐ Yes ☐ No

*Red Mountain Med Spa, Red Mountain Weight Loss, Tucson Medical Weight Loss, Tucson Medical Weight Loss & Med Spa

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WEIGHT LOSS

New Patient Information

Current Medications: _____

_____

Medication Allergies: _____

Allergies: _____

Please list any surgeries with dates: _____

_____

Please list any complications with the surgeries: _____

_____

Please list any recent or current medical conditions that we should be aware of: _____

_____

Do you have a personal or family history of any of the following conditions?

Heart Disease:	☐ Personal	☐ Family	Blood Disorders:	☐ Personal	☐ Family
Kidney Disease:	☐ Personal	☐ Family	Depression:	☐ Personal	☐ Family
Lung Disease:	☐ Personal	☐ Family	Seizures:	☐ Personal	☐ Family
Diabetes:	☐ Personal	☐ Family	Sexually Transmitted Diseases:	☐ Personal	☐ Family
Nervous Disorders:	☐ Personal	☐ Family	Developmental Disability:	☐ Personal	☐ Family
Cystic Fibrosis:	☐ Personal	☐ Family	Hypertension:	☐ Personal	☐ Family
Cancer:	☐ Personal	☐ Family			

Please select the appropriate answer:

Are you pregnant?	☐ Yes	☐ No
Are you on Chemotherapy or Radiation Therapy?	☐ Yes	☐ No
Are you allergic to Xylocaine or Novocaine?	☐ Yes	☐ No
Are you allergic to Latex?	☐ Yes	☐ No
Are you taking Accutane or any sun-sensitive medications?	☐ Yes	☐ No

Do you smoke? ☐ Yes ☐ No If yes, how long? _____ How many per day? _____

Do you drink? ☐ Yes ☐ No If yes, how many per day? _____ Per week? _____

Do you have a pacemaker?	☐ Yes	☐ No
Do you have a history of cold sores or herpes virus?	☐ Yes	☐ No
Do you have a history of Vitiligo (Lightening of the skin)?	☐ Yes	☐ No
Do you have a hormone condition?	☐ Yes	☐ No
Do you have a history of numbness on any part of your face or body?	☐ Yes	☐ No
Do you have a history of Keloid scarring?	☐ Yes	☐ No
Do you take aspirin on a regular basis OR take any blood thinners?	☐ Yes	☐ No
Do you have any metal surgical implants?	☐ Yes	☐ No
Have you been diagnosed with an autoimmune disease?	☐ Yes	☐ No
Have you been diagnosed with diabetes?	☐ Yes	☐ No
Do you currently have chicken pox, measles, mumps or any other diseases?	☐ Yes	☐ No

If yes, please list: _____

Tucson Medical WEIGHT LOSS

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Office and Financial Policies

We would like to thank you for choosing us for your medical and aesthetic needs. As one of our patients, we would like to keep you informed of the current office and financial policies for this establishment and all subsidiaries*.

Please read each of the following sections carefully and initial:

Insurance:
This establishment and all subsidiaries* do **NOT** participate with any insurance companies. We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnosis codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance companies.

Initial: _____

Payment:
ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, however, some services may require a deposit in advance. This establishment and all subsidiaries* only accepts payment in the form of cash, VISA, MasterCard, American Express or Discover, Advance Care Card and Care Credit. WE do NOT accept checks.
*Care Credit cannot be combined with any offer, special or discount, and minimum purchase required.

Initial: _____

Refund Policy:
Our establishment and all subsidiaries* will provide patients with prescription medication and are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription medications for refund. **ALL SALES ARE FINAL.** Before a service is performed please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer.

Initial: _____

Appointments:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. **There is a charge of $25.00 to $150.00 per hour for missed or late-canceled appointments.** Excessive abuse of scheduled appointments may result in discharge from the practice.

Initial: _____

Appointment Times:
As our patient, we value your time and want to be as transparent as possible in regards to how long you should plan on being in the office for your appointments. New Patient appointments typically take an hour to an hour and a half from check-in to check-out. Follow-up appointments usually take 45 minutes to an hour from check-in to check-out. There are certain times of the day when appointments are in higher demand and we are a bit busier. When scheduling your appointments, please let us know if you prefer to schedule during a less busier time of the day and we will be happy to accommodate you.

Initial: _____

Prescription Medication:
Many of the medications that are prescribed by the medical providers of this establishment and all subsidiaries are deemed as controlled substances and must be monitored regularly. All patients are required to have an appointment with a medical provider in order to receive any prescription refills. The controlled medications will be dispensed in office at the time of your visit. If you choose, we can provide you with a written prescription to have filled at the pharmacy of your choice; however, a program fee will still apply.

Initial: _____

Lab Work:
Lab work is mandatory for all weight loss programs. I understand that my lab work needs to be completed within the first week following my initial appointment. I also understand that if the results are not received by this establishment prior to my second appointment, that I will not be prescribed any additional medication.

Initial: _____

Guarantee:
As in any procedure, treatment or program, there is no guarantee of any particular results. Results will vary based on each individual patient.

Initial: _____

Electronic Recording:
To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits. Additionally, all conversations between the medical provider and patient are documented in the patient's medical chart. To review this information, a patient may request a copy of their medical records.

Initial: _____

Services Policy:
I understand that this establishment and all subsidiaries* have the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain medical services and it is at the full discretion of the medical provider to determine whether I am a candidate for any service provided.

Initial: _____

I have read, understand and agree to the office and financial policies set forth by this establishment and all subsidiaries*.

Patient or Legal Guardian's Signature: _____ Date: _____

Patient's Name (Please Print): _____

At your request, a copy of these policies can be provided for you.

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Tucson Medical WEIGHT LOSS

New Patient Information

Notice of Privacy Practices

In accordance with HIPAA federal regulations, this establishment and all subsidiaries* will not disclose any information about you or your personal health, without your permission. All information received while a patient (and if/when you decline to be a patient no longer) will be kept confidential.

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, you consent to the use and disclosure of your protected health information by our staff, and our business associated ***strictly for the purpose of treatment, payment and health care operations.***

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. It provides more detail on how we may use and disclose of your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, by contacting our office manager.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information ***for the purposes of treatment, payment and health care operations.***

Patient or Legal Guardian's Signature: _____ Date: _____

Patient's Name (Please Print): _____

For Practice Use Only:

For Practice Use Only:

Check the appropriate reason:

- ☐ Indirect Treatment Relationship
- ☐ Emergency Treatment
- ☐ Substantial Communication Barrier
- ☐ Refusal to Sign

Description: _____

Practice Signature: _____ Date: _____

Witness: _____ Date: _____

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Cancellation Policy

I understand that I am responsible for the following fees, if a 24 hour notice to reschedule or cancel my appointment is not given. These fees also apply to missed appointments.

• Weight Loss Appointments:	$25.00
• Hormone Treatment Appointments:	$50.00
• Injectable Appointments:	$50.00
• Aesthetic Appointments:	$50.00
• Body Contouring:	$150.00/Treatment Hour

I understand that I will be billed for this fee and payment is due before I can reschedule my next appointment.

Patient or Legal Guardian's Signature: _____ Date: _____

Patient's Name (Please Print): _____

Tucson Medical WEIGHT LOSS

New Patient Information

CONSENT - WEIGHT LOSS CONSULT

I authorize this establishment and all subsidiaries* to assist me in my weight loss reduction efforts.
Potential Risks:

- Allergic reactions to prescribed medication and supplements
- Side effects of medication
- Inconvenience of lifestyle changes

I understand that some medications and supplements may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain existing disease conditions.

I do not expect my medical provider to be able to anticipate and explain all risks and potential complications. I wish to rely on the judgment of the medical providers in recommending programs that they feel are in my best interest, based on the available knowledge.

I have the opportunity to ask questions and discuss with the medical staff to my satisfaction:

- My condition
- The nature, purpose, and potential benefit of the proposed medical weight loss program(s)
- The potential risks associated with the medical weight loss program(s)
- The probability of those risks occurring
- The likelihood of success
- The possible consequences if advice is not followed and/or no weight loss programs are undertaken

Acknowledgement of Laboratory Procedures:
I understand that this establishment and all subsidiaries* have a contracted account with a specific laboratory. This contract is only for specific blood draws. It is against the law for a patient to add any additional tests to a lab order. I understand that if I add any additional blood tests to a lab order, or if I request the laboratory to add additional blood tests under this establishment and all subsidiaries* account, I am responsible for all charges in addition to the cost of the initial visit fee.

I understand that the payment for the required blood tests are included in the cost of the initial visit and are nonrefundable, nor can the charge for blood tests be deducted from a program's price for any reason. All affiliated offices*and providers are not in network with any insurance companies. Because of this, patients and laboratories are not permitted to submit any claims to insurance.

I understand that I am permitted to have my blood drawn only at a designated laboratory location with an approved lab order slip. If I have my blood drawn under a provider, name, or account, at any laboratory other than the one designated, I am responsible for all charges.

I understand that this establishment and all subsidiaries* do not replace the services of my primary care physician or specialist (e.g. Oncologist, Cardiologist, OB-Gyn, etc.). I will discuss all my prescription medication questions and changes, not prescribed by this establishment and all subsidiaries*, with my primary care doctor and/or specialist.

Injections Consent:
My medical provider may prescribe a Vitamin Shot and/or RM3 Fat Burning Shot that must be given by intramuscular (IM) injection. IM injections use a needle and syringe to deliver medication to large muscles in my body. They are usually given in the buttock, thigh, hip, or upper arm. Treatments are typically well tolerated with no serious adverse reactions.
Potential Side Effects:

- Injection Site Reaction – Temporary redness, pain or tenderness, and irritation of the skin surrounding the injection site.
- Bruising – This response is temporary and may occur at the site of the injection.
- Infection – Very rare complication but possible anytime an injection through the skin is performed.

I have fully read and understand this consent form, and I realize that I should not sign this form if I have any questions concerning these injections. I understand the potential side effects, benefits and give my consent to receive these injections.

Initial: _____

FEMALE PATIENTS ONLY: I certify that I am not pregnant at this time, and if I do become pregnant I will immediately stop the weight loss program along with any weight loss medication, and notify this office immediately.

Initial: _____

Patient or Legal Guardian's Signature: _____ Date: _____

Patient's Name (Please Print): _____

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