2017
Medi-Slim Weight Loss
Patient Information Form

Patient Name (Last)_______________________________ (First)____________________________________ (MI)________

Name you prefer to be called:____

Patient Address:____

City:____ State________________________________ Zip______________

Phone number you would prefer us to use:____

May we email you? Yes / No

If yes, email address:____

Birthdate:____ Age:______________________ Sex: M F

Employment Information:

Patient Employer:_____________________________________ Occupation:____

Driver's License Number:____ State:___________________________________

In Case of Emergency:

Name:____ Relationship:_________________ Phone:_______________

Family Physician:____ Phone:_______________

How did you hear about us? (Please circle one)

Drive-by TV Brochure Internet Yelp Friend/Relative

If referred, by whom:____

We appreciate referrals. When you refer another patient, you will receive $20 off your next visit!

Financial Policy:

Thank you for selecting Medi-Slim Weight Loss and Dr. Pamela Gabriel for your weight management needs. We are honored to be of service to you, your family and friends. This is to inform you of our financial policy.

********Please read and initial the items below. **********

____ Payment for all services will be due at the time services are rendered. There will be no exceptions.
For your convenience, we accept all major credit cards, Debit Cards, checks and cash.

____ Payment for packages must be completed before treatment has begun.

____ Package treatments must be completed within 6 months of the date of purchase or they will expire.

____ Packages cannot be transferred to another patient or changed to another service.

____ We do not offer refunds.

____ We cannot accept returns of any food items.

____ If a patient is to return after being absent for 12 months, the full new patient price will be applicable.

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

____ ______________________________________

Patient Signature Date

2017
Patient Medical History Form

Past Medical History: (Circle all that apply)

Polio	Measles	Tonsillitis
Jaundice	Mumps	Pleurisy
Kidney Disease	Scarlet Fever	Liver Disease
Lung Disease	Whooping Cough	Chicken Pox
Rheumatic Fever	Bleeding Disorder	Nervous Breakdown
Ulcers	Gout	Thyroid Disease
Anemia	Heart Valve Disorder	Heart Disease
Tuberculosis	Gallbladder Disorder	Psychiatric Illness
Drug Abuse	Eating Disorder	Alcohol Abuse
Pneumonia	Malaria	Typhoid Fever
Cancer	Blood Transfusion	Arthritis
Osteoporosis	Heart Attack	Illegal Drug Use
Diabetes	High Blood Pressure	Drug Dependence

Other:____

Serious Injuries: (Only if it effects ability to exercise) Yes No

____

____

Any Major Surgery Yes No

____

____

History of Sleep Apnea Yes No

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father					
Mother					
Brothers					
Sisters					

2017
Patient Medical History Form

Patient Name:____ Date______________________

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

If No, Please explain

____

____

____

2. Are you under a doctor's care at the present time for any reason? Yes No

If yes, for what reason(s)?

____

____

____

3. Are you taking medications (prescription, over-the-counter, herbal or vitamins) at the present time? Yes No

Medication **Dosage**

____

____

____

____

____

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____

____

____

____

Any Allergies to Any Medications? Yes No

Specify:_____________________________________

____

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____

Medi-Slim Weight Loss & Spa, LLC
NOTICE OF USE OF PRIVATE HEALTH INFORMATION

Medi-Slim Weight Loss & Spa, LLC complies with the privacy and security standards outlined by the Health Insurance Portability and Accountability Act (HIPAA). Specifically,

- We maintain physical security of your medical records.
- We only share information about you that is needed at the time by the provider or staff to do our job.
- Medi-Slim Weight Loss & Spa, LLC sends information to your insurance company or to a government only if requested by you, the patient. That information is about the services you received.
- You are allowed to see your medical information and to have a copy of your medical record, unless it is the private notes taken by a mental health provider or is part of a legal case.
- If you think some of the information in your medical record is incorrect, you may submit a written request to have it changed. We will consider your request and tell you what we have decided.
- You may ask for a list of places where your medical information was sent if it was not sent as part of your provider's care or used to be sure that you received quality care and all laws about medical care are met.
- If you ask to have your medical information sent to another health care provider or to another person, you must sign an authorization form which tells us which information to send, where, and to whom to send it. This authorization is good for the specific dates and types of information specified on your authorization form. If more information is requested at a later date, you will have to sign another authorization form.
- If you are less than 18 years old, your parents or guardians may receive your medical information without your consent, unless you are able to consent for your own healthcare.
- We are required by law to release certain medical information without your consent in certain instances.
    - Contagious diseases
    - Reactions and problems with medicines
    - To the police when they are investigating a crime, when child or elder abuse may be suspected, or when the court orders us to
    - To a provider or other insurance who needs to know if you have Medicaid
    - Work related injuries to worker's compensation
    - Birth, death, and immunization information
    - To the Federal Government when they are investigating something important o protect our country, the president or other government agencies.
- When we refer you to another provider or service for health care, we provide them only the medical information required for that visit or service.
    - You may refuse in writing to consent to the use or disclosure of your medical information.
    - If you choose to refuse to let us use or disclose your medical information, the law allows us to refuse to treat you.
- If you choose to allow us to disclose your medical information, you may submit a future request not to disclose any further information.
- If you have concerns or questions about the security or privacy of your medical information, please contact Rogayle Freeman at the clinic or by telephone 702-258-8456.
- Your services will not be affected by bringing your concerns to our attention.

I acknowledge receipt of this Notice of Use of Private Health Information.

Patient Name: ____________________________________ Date: ______________________

Signature: ____
(Parent or guardian if under 18)

(for use until 12/31/18)

2017

Weight Loss Program Consent Form

I, ____ authorize Dr. Pamela Gabriel and whomever she designates as her assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplement diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. I understand 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 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 obesity may be a chronic, life-long condition that 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 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 now before signing this consent form.

____ ____

Patient or guardian Date

____

Office Staff