

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

Welcome and thank you for taking an interest in improving your health by losing weight.

Weight Loss

If you want to lose weight, we can help. No matter how much or how little weight you have to lose, we can help. We offer a program that can produce impressive results in a relatively short period of time. The program consist primarily of a low carbohydrate diet and exercise. We can also assist your weight loss with lipotropic injections and/or pills, B12 injections that are recommended and most effective if taken weekly. We also have many other products that will be discussed individually with you as the need arises. Each of our products has been shown to assist weight loss, and each of our products works differently and together to increase your weight loss. The nurse practitioner will discuss products with you as your weight loss progresses, depending on your weight loss needs or difficulties. We also provide you with diet suggestions, recipes, exercise suggestions, a 12 week individualized exercise program – offered by Frontera Mobile Diagnostics (which is covered by BCBS, Tricare and Medicare) or calculated by our fitness expert, and weekly weight loss support. We recommend you return every week for injections, blood pressure check, and weight, body fat and weight loss assessment and encouragement. There is no charge for weekly visit

IgG and IgA Testing

If you have had difficulty losing weight in the past or have fatigue, headaches, joint aches, muscle soreness or aches, rashes, psoriasis, eczema, skin redness, abdominal bloating, pain, irritable bowel syndrome and as many as 100 other medical problems, you may have delayed onset IgG or IgA antibodies or food sensitivities. We provide extensive testing. This testing is covered by Cigna, BCBS, Humana and Aetna PPO or EPO. If you have HMO and wish to have this testing please ask for a form for your primary care physician to sign and return with it to our clinic and we would be glad to complete the testing for you.

Medications

One small part of our program may be a prescription for a stimulant, appetite suppressant. IF YOUR BODY MASS INDEX IS LESS THAN 25 YOU CANNOT QUALIFY FOR the APPETITE SUPPRESSANT – it is highly regulated by the FDA, DEA etc. The appetite suppressant is approved by the FDA for overweight, obese and morbidly obese people. We cannot prescribe it to anyone with a BMI less than 25 on your first visit.

If your body mass index is over 25 you are considered overweight. Just because you are overweight, you may not qualify for an appetite suppressant. If you have even one of the following conditions you cannot take a stimulant. If you are pregnant, breast-feeding, have glaucoma, an overactive thyroid, have high blood pressure, heart disease, or are taking an MAOI antidepressant such as Nardil, Parnate, or Marplan. Also, there is no “lose weight overnight pill”.

Today your consultation consists of a general health assessment including blood pressure, weight, height, hip to waist circumference ratio and body fat analysis. We will also draw blood for tests to check your kidneys, liver, and thyroid, blood sugar and cholesterol. We may also recommend other tests based on your and your family health history.

**All visits with the Nurse Practitioner are \$60. She can offer you and your family medical visits for minor illnesses as well as weight loss.**

For weight loss it is recommended that you have a B-12 injection and a lipoden injection weekly. The B-12 injection is \$10. The lipoden injection is \$25.

If you qualify for the appetite suppressant you will need to have an monthly visit with the nurse practitioner at \$60.00 each month for a brief physical exam and a new prescription for the appetite suppressant.

Once again, we recommend that you return weekly for weight, blood pressure and general assessment.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB : \_\_\_\_\_ Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

Patient Information Form

**Personal Information:**

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Country of Parents' Birth: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred by: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Employment Information:**

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone No: \_\_\_\_\_ Ext. \_\_\_\_\_ Drivers License: \_\_\_\_\_

**In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Financial Policy:**

Thank you for selecting True Weight Loss Clinic for your weight loss needs for your weight loss needs. 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 time services rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and Discovery.

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 all of the above and have agreed to these statements.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB : \_\_\_\_\_ Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

**PATIENTS PLEASE FILL THIS OUT TO LET US KNOW IF YOU HAVE ANY PROBLEMS  
WITH ANY OF THESE SYSTEMS.**

**General- NONE**

- Weight loss or gain
- Weakness
- Fatigue  Trouble sleeping

**Head- NONE**

- Headache  Head injury

**Ears- NONE**

- Decreased hearing
- Ringing in ears (tinnitus)
- Earache  Drainage

**Eyes- NONE**

- Vision  Glasses or contacts
- Pain  Redness
- Blurry or double vision
- Flashing lights  Specks
- Glaucoma  Cataracts
- Last eye exam

**Neck- NONE**

- Lumps  Swollen glands
- Pain  Stiffness

**Respiratory- NONE**

- Cough (dry or wet, productive)
- Shortness of breath (dyspnea)
- Wheezing  Painful breathing

**Cardiovascular- NONE**

- Chest pain or discomfort
- Tightness  Palpitations
- Shortness of breath with activity (dyspnea)
- Difficulty breathing lying down (orthopnea)
- Swelling in feet or hands (edema)
- Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

**Gastrointestinal- NONE**

- Swallowing difficulties  Heartburn
- Change in appetite  Nausea
- Change in bowel habits
- Rectal bleeding  Constipation
- Diarrhea  Yellow eyes or skin (jaundice)

**Vascular- NONE**

- Calf pain with walking (Claudication)
- Leg cramping

**Musculoskeletal- NONE**

- Muscle or joint pain  Stiffness
- Back pain  Redness of joints
- Swelling of joints  Trauma

**Neurologic- NONE**

- Dizziness  Fainting
- Seizures  Weakness
- Numbness  Tingling  Tremor

**Endocrine- NONE**

- Head or cold intolerance  Sweating
- Frequent urination (polyuria)
- Thirst (polydypsia)
- Change in appetite (polyphagia)

**Psychiatric- NONE**

- Nervousness  Depression
- Memory loss  Stress  Anxiety

Date of latest EKG _____
Date Of Latest Echocardiogram _____

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB : \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC**  
**13450 RESEARCH, SUITE 115**  
**AUSTIN, TX 78750**  
**Medical History**

**Present Health Status:**

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

Do you see a medical provider regularly? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

Explain a "no" answer: \_\_\_\_\_

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

Please list all medications: Prescription and over the Counter Drugs:

Drug:

Dosage:

_____	_____
_____	_____
_____	_____

4. do you have any allergies to any medications? \_\_\_\_ Yes \_\_\_\_ No Please list: \_\_\_\_\_

5. Gynecological History: Pregnancies : Number: \_\_\_\_\_ Dates: \_\_\_\_\_

Natural Delivery or Cesarean Section ? \_\_\_\_\_

Menstrual History : Are your periods regular? \_\_\_\_ Yes \_\_\_\_ Pain Associated ? \_\_\_\_ Yes \_\_\_\_ No

Birth control method : \_\_\_\_\_ LNMP; \_\_\_\_\_

6. Serious Injuries: \_\_\_\_ Yes \_\_\_\_ No Specify (list all) \_\_\_\_\_

\_\_\_\_\_

7. Any Surgery: \_\_\_\_ Yes \_\_\_\_ No Specify: (List all) \_\_\_\_\_

\_\_\_\_\_

8. Family History: (check all that apply)

\_\_\_\_\_ Alcohol Abuse \_\_\_\_\_ Diabetes \_\_\_\_\_ Eating Disorder \_\_\_\_\_ Heart Valve Disorder

\_\_\_\_\_ Heart Disease \_\_\_\_\_ Hypertension \_\_\_\_\_ Kidneys disease \_\_\_\_\_ Liver Disease

\_\_\_\_\_ Psychiatric Illness \_\_\_\_\_ Thyroid Disorder Other: \_\_\_\_\_

9. Personal Past Medical History: (check all that apply)

\_\_\_\_ Alcohol Abuse \_\_\_\_\_ Anemia \_\_\_\_\_ Arthritis \_\_\_\_\_ Cancer \_\_\_\_ Diabetes \_\_\_\_ Type 1

Diagnosed at what age ? \_\_\_\_ Type 2 Diagnosed at what age ? \_\_\_\_\_ \_\_\_\_\_ Recreational Drug Use/Abuse

\_\_\_\_\_ Eating Disorder \_\_\_\_\_ Gallbladder Disorder \_\_\_\_\_ Gout \_\_\_\_\_ Heart Valve Disorder

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC**  
**13450 RESEARCH, SUITE 115**  
**AUSTIN, TX 78750**

\_\_\_\_\_ Heart Disease \_\_\_\_\_ Hypertension \_\_\_\_\_ Kidneys disease \_\_\_\_\_ Liver Disease \_\_\_\_\_  
Psychiatric Illness \_\_\_\_\_ Thyroid Disorder \_\_\_\_\_ Headaches/Migraines \_\_\_\_\_ Glaucoma

**Other Past Medical History:** \_\_\_\_\_

**Nutrition Evaluation:**

1. Present Weight: \_\_\_\_\_ Height (no shoes): \_\_\_\_\_ Desired Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ lbs

2. What is the main reason for your decision to lose weight? \_\_\_\_\_

3. What has been your maximum lifetime weight (non-pregnant) and when? \_\_\_\_\_

4. Previous diets you have followed: Give dates and results of your weight loss: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Is your spouse, or partner overweight? Yes \_\_\_\_ No \_\_\_\_ By how much is he or she overweight? \_\_\_\_\_

6. Who plans meals at home ? \_\_\_\_\_ Cooks? \_\_\_\_\_ Shops? \_\_\_\_\_

7.. Food(s) you crave: \_\_\_\_\_

8. Do you drink alcohol? \_\_\_\_ Yes \_\_\_\_ No What? \_\_\_\_\_ How much daily? \_\_\_\_\_  
Weekly? \_\_\_\_\_

9. Do you awaken hungry during the night? Yes No What do you do? \_\_\_\_\_  
\_\_\_\_\_

10. What are your worst food habits? \_\_\_\_\_

11. Snack Habits: What? \_\_\_\_\_ How much? \_\_\_\_\_ When? \_\_\_\_\_

12. Typical Breakfast: \_\_\_\_\_

Time eaten: \_\_\_\_\_ Where: \_\_\_\_\_ With whom: \_\_\_\_\_

Typical Lunch: \_\_\_\_\_

Time eaten: \_\_\_\_\_ Where: \_\_\_\_\_ With whom: \_\_\_\_\_

Typical Dinner: \_\_\_\_\_

Time eaten: \_\_\_\_\_ Where: \_\_\_\_\_ With whom: \_\_\_\_\_

13. Activity Level: (answer only one)

\_\_\_\_\_ Inactive—no regular physical activity with a sit-down job.

\_\_\_\_\_ Light activity—no organized physical activity during leisure time.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

\_\_\_\_\_ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

\_\_\_\_\_ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..

\_\_\_\_\_ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

14. Behavior style: (answer only one)

\_\_\_\_\_ You are always calm and easygoing.

\_\_\_\_\_ You are usually calm and easygoing.

\_\_\_\_\_ You are sometimes calm with frequent impatience.

\_\_\_\_\_ You are seldom calm and persistently driving for advancement.

\_\_\_\_\_ You are never calm and have overwhelming ambition.

\_\_\_\_\_ You are hard-driving and can never relax.

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

12 Reasons why I want to lose weight:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

PATIENTS Please Initial Beside Each Statement That You Do Not Have These Conditions

\_\_\_\_\_ I do not currently have hyperthyroidism

\_\_\_\_\_ I do not currently have and never have been treated for glaucoma (a condition of increased pressure in the eyes)

\_\_\_\_\_ I do not currently have and have never been treated for heart/cardiovascular disease.

\_\_\_\_\_ I am not taking MAOI inhibitors (an old type of antidepressant) nor have I taken them in the past 14 days.

\_\_\_\_\_ I do not currently have not have I ever had arteriosclerosis (hardening of the arteries)

\_\_\_\_\_ I do not currently have and have never been treated for moderate or severe hypertension (high blood pressure)

\_\_\_\_\_ I do not currently have and have never been treated for anxiety disorder or agitation, bipolar disorder.

\_\_\_\_\_ I do not currently have, have never been in treatment for nor do I have a history of drug abuse.

\_\_\_\_\_ I am not currently pregnant nor do I plan to become pregnant while under medical treatment at True Weight Loss Clinic and am taking precautions to not get pregnant at this time.

\_\_\_\_\_ I am not currently breastfeeding.

\_\_\_\_\_ I am not currently taking any other prescription appetite suppressant or diet medication.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **Patient Informed Consent for Appetite Suppressants**

### **I. Procedure And Alternatives:**

1. I, \_\_\_\_\_ (patient or patient's guardian) authorize Cynthia Hodgins APRN, MSN, FNP-C 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.

2. I have read and understand my provider's statements that follow:

"Medications, including the 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 12 weeks) using the dosages indicated in the labeling.

"As a bariatric provider, 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 provider, 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 bariatric provider, 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 provider 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 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.

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 suppressants.

### **II. Risks of Proposed Treatment:**

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 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 heart beat 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.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

**III. 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 high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

**IV. 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 continue watching my weight all of my life if I am to be successful.

**V. 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.

**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, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**PATIENT:** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_  
(or person with authority to consent for patient)

**VI. PROVIDER 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 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. A medication handout has been provided to the patient with extensive information about prescription appetite suppressants and my recommendations for use of them.

\_\_\_\_\_  
**Provider's Signature**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **Weight-Loss Consumer Bill of Rights**

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program.

I have read the above:

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115  
AUSTIN, TX 78750**

**TRUE WEIGHT LOSS CLINIC  
13450 RESEARCH, SUITE 115 AUSTIN, TX 78750**

---

## **NOTICE OF PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT**

All patients have the right to have confidential care provided. All information, Medical or Social, whether written, spoken, electronic or computer generated, is to be held in strict confidence.

By signing below you acknowledge receipt or availability of receipt of the True Weight Loss Clinic Notice of Privacy Practice. This notice explains how True Weight Loss Clinic may use and disclose your protected health information for treatment, payment and health care operation purposes. "Protected Health Information" means your personal health information found in your medical and billing records. True Weight Loss Clinic reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice is posted at patient service locations throughout True Weight Loss Clinic. The effective date of the notice appears on the first page of the notice or summary. In addition, True Weight Loss Clinic has available for you at your request, a copy of the current notice in effect.

**Your signature below acknowledges that you are aware that there is a privacy notice located in the clinic available for you. That your have been offered a copy of the privacy notice and have received or declined said copy.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_