DR. COLLADO'S WEIGHT LOSS PROGRAM

LEGAL NAME AS ON I.D.: _____

DOB: (MM/DD/YYYY): _____ Social Security #: _____

Sex (Gender): Female Male Other_____

Street Address (No PO Boxes): _____

City, State, Zip: _____

Please note we're limited to those within Oklahoma, but an out-of-state ID is not a problem.

_____ _____

Primary Phone # How did you hear about us?

_____

Email Address:

EMERGENCY CONTACT:

_____ _____ _____

Emergency Contact Name Phone Number Relation to Patient

Carefully read Page D regarding those that do & do not qualify for program.

OFFICE USE

New Patient Information Check List

Informative Video _____

Weight Loss Associate _____

Met with Physician or NP _____

Informed of Payment / Cost _____

X_____

Date: _____

If any adult patient is joining you during your appointment, please read and sign the back page.

GROUP PATIENT CONSENT FORM

This form is needed if you are to be seen with another patient such as a family member, spouse, friend, or any adult that you authorize to be in the room during your appointment. This is to ensure that your personal medical information can be said out loud.

Please note ONLY patients can go to a patient room.
Those that are not patients will need to wait in the waiting room.

I _____, agree that anyone that is in the room with me is authorized to know my weight, blood pressure, waist size, body mass, age, height, and weight lost or gained. I also allow the person(s) in my group to know my weight loss goals, medications, and medical disadvantages. I agree to respect the other person(s) in the group. I will keep all information discussed about the other person(s) confidential.

_____ _____
Signature Date

PATIENT HEALTH QUESTIONNAIRE

NAME_____ DOB:_____ GENDER_____

1. Has a physician ever told you that you have any heart conditions?	Y	N
2. Do you have a history of chest pain?	Y	N
3. Do you have a history of dizziness?	Y	N
4. Do you have a history of seizures?	Y	N
5. Do you have a history of strokes?	Y	N
6. Do you have a history of bone or joint problems?	Y	N
7. Are you aware of any reasons why you cannot perform physical activity?	Y	N
8. Are you pregnant or planning to get pregnant in the next 6 months?	Y	N
9. Are you taking any psychiatric medications?	Y	N
10. Are you currently prescribed any ADHD or ADD medications?	Y	N
11. Are you taking any weight loss medications (prescribed or over the counter)?	Y	N
12. Are you allergic to any medications?	Y	N
13. Have you ever been charged with any illegal activities relating to substance abuse or alcohol?	Y	N
14. Do you have any reasons why you may be unable to lose weight?	Y	N
15. Do you have problems controlling your weight?	Y	N
16. Do you smoke?	Y	N
17. Do you exercise regularly?	Y	N
18. Do you have depression, anxiety, and/or increased stress do to your weight?	Y	N
19. (Females) Do you have a history of eclampsia, preeclampsia, gestational diabetes, or gestational hypertension?	Y	N
20. Do you have any **family history** of heart disease, high blood pressure, diabetes, stroke, heart attack, and/or high cholesterol? If so, please list below:	Y	N

_____

_____

21. If you are currently taking any prescription medication(s), please list them (prescribed or over the counter):

_____

_____

Please use the space below to provide any additional information if you chose **YES** to any of the above:

_____

_____

I understand that exercise can create physical stress and possible harmful effects. I agree it is entirely my responsibility to consult with my physician prior to initiating an exercise program. I also understand that exercise equipment can cause injuries and take full responsibility for my actions or accidental injury.

_____

Patient's signature Date

(Office Use) Reviewed & Cleared for Weight Loss Program

_____

MD Signature Date

DR. COLLADO'S WEIGHT LOSS PROGRAM INFORMED CONSENT

1. I agree to exercise on a regular basis as directed by the physician and weight loss specialist.
2. I agree to follow the dietary and meal portion recommendations.
3. The use of the appetite suppressant medication is optional to the patient.
4. The appetite suppressant medication is prerogative of the physician, based on patient's medical status.
5. The use of the appetite suppressant medication is part of the program, but does not constitute the full program itself.
6. It is the physician's prerogative to stop the medication at any time because of failure to comply with the weight loss program agreement, misuse of medication, or medical concern.
7. If you are taking or prescribed any stimulant medications, you do not qualify for the prescription.
8. I agree to come as frequent as required by the physician or weight loss specialist, based on my weight loss results.
9. During the weight loss program, weight loss is a must. Continual fluctuation or stalled weight loss may result in break.
10. Patients with a Body Mass Index (BMI) above 30.0 (Obesity) will require a weight loss of 3 pounds per month.
11. Patients with a BMI less than 30.0, will be required to lose 1 pound.
12. If patient has a BMI between 27.0—29.9 (overweight) and two or more risk factors for heart disease or comorbidities, patient may qualify for the program per the physician's prerogative.
13. If an established patient reaches a BMI of 24.9 or lower (healthy), patient will begin the one-month wean off process.
14. Any new or restarting patient with a BMI of 26.9 or lower will not qualify for the weight loss program. If you have a BMI of 26.9 or less you do not qualify unless you have a letter from your specialist or primary care provider listing what your need is to lose weight for your health benefit. Patient may qualify for the program per the physician's prerogative.
15. Once the patient finishes the program or weans off, they must be away from the program for 1 month before any restart consideration. A BMI 27.0 or less requires medical authorization.
16. We only accept cash or credit/debit cards. We do not file anything under the insurance companies. We do not accept checks, Benny cards, Health Savings Account cards, or any kind of Benefit cards.
17. Prescriptions will not be sent to the pharmacy until payment has been made.
18. Letters from the physician or paperwork completed by the physician (even for patient's employer) will cost up to $75.
19. Prescriptions will not be given earlier than 2 days from your 30-day or 15-day follow-up. Patient is responsible to keep medication in a safe place. We recommend patients keep their medication secured at their home and not in a vehicle.
20. It is a felony to share or sell your prescription.
21. Dr. Collado's Weight Loss Program uses the PMP database from the Oklahoma Bureau of Narcotics & Dangerous Drugs to track prescription usage and prescribed controlled substances. (1) If you are found to be prescribed or receiving the same or similar drugs from other physicians, you will be terminated from the program immediately. (2) Registered methamphetamine users do not qualify for program.
22. Per the Oklahoma Bureau of Narcotics & Dangerous Drugs (OBNDD) as of January 1, 2020, prescriptions that are controlled substances are required to be sent electronically.
23. Patient has the right to ask any questions or request further information about the weight loss program.
24. Patient may terminate the program at any time. The readmission is the physician's prerogative.
25. Cancellations and reschedules must be notified within 24 hours of their appointment by calling 405-601-1729.
26. Our clinic will charge $5.00 for No Shows during regular weekday business hours. This charge must be paid before the patient is seen the next visit.
27. Please advise your primary care physician about the use of the medication. In addition, please keep us informed of any new medical conditions or change in prescriptions prior to your appointment.
28. Patients that do not qualify: 65-years-old or older, history of heart disease (heart attacks, chest pain, cardiac stents, stroke, heart failure, uncontrolled high blood pressure), pregnant and/or breastfeeding, seizure disorder, prior drug abuse or drug dependencies, registered meth offense, taking Wellbutrin (Bupropion), taking Trintellix (Vortioxetine) or Brintellix, decreased kidney function.

I have read and consent to participate in Dr. Collado's Weight Loss Program.

X_____

Patient Signature Date

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HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

If you have any questions about this notice, please contact Dr. Collado or Dr. Rivera.

Who will follow this notice:
This notice describes our office's practices and that of:

- Any health care professional authorized to enter information into your file or record.
- All employees, staff, and other personnel.
- All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share information with each other for treatment and/or payment.

Our pledge regarding medical information: We understand that medical information about you are your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of the medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose your medical information:
Appointment reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.
As required by law: We will disclose medical information about you when required to do so by federal, state or local law.
To avert a serious threat to health or safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks: We may disclose medical information about you for public health activities. These activities may include reporting reactions to medications or problems with the medication.
Health Oversight Activities: We may disclose medical information to a health oversight agency for activities by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil right laws.
Lawsuits & Disputes: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about request or to obtain an order protecting the information requested.
Law Enforcement: We may release medical information if asked to do so by law enforcement officials in response to a court order, subpoena, warrant, summons, or similar process.
Your Rights Regarding Medical Information About You: You have the right to request a copy of your medical records, however, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. You are welcome to come to the office to view your information, but we will not provide your personal or medical information over the phone.
Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment, for as long as the information is kept by our practice. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request. In addition, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request.
Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. To request the list or accounting of disclosures, you must submit your request in writing.
You have a right to a copy of this notice. You may ask us to give you a copy of this notice at any time. We reserve the right to change this notice at our discretion.

X

Patient Signature Date

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Patient Rights, Responsibilities, & Consent

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities.

You have the right to:

- A personal clinician who will see you on an on-going, regular basis as required.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illness, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, you are responsible for calling and speaking to a staff member at least 24 hours in advance. Cancellations cannot be completed via voicemail, email, or social media.
- Paying payments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Patient Consent

Consent to Medical Care & Treatment
I am being treated at Dr. Collado's Weight Loss Program ("Physician Office"), and I consent to weight loss program examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance.

Request for Information from Others: I consent to the Physician Office's request of my health information from other providers.
Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the Physician Office may use or disclose PHI for purposes of treatment, payment, or health care operations.
Financial Responsibility: I understand and agree that I am financially responsible for payment of all charges.
Personal Valuables: I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

X

Patient Signature Date