# Dr. Edward G. Mackay

Vein & Circulation Specialists Vivaliti Weight Loss Program

## Patient Information (Please Print)

| FIRST NAME | LAST NAME | DATE |
|---|---|---|
| | | |

| DATE OF BIRTH | AGE | GENDER | SOCIAL SECURITY # |
|---|---|---|---|
| | | ☐ Male ☐ Female | |

| STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| EMPLOYER | OCCUPATION |
|---|---|
| | |

| WORK PHONE | HOME PHONE |
|---|---|
| | |
| Can we leave a message at this number? ☐ Yes ☐ No | Can we leave a message at this number? ☐ Yes ☐ No |

| CELL PHONE | EMAIL ADDRESS |
|---|---|
| | |
| Can we leave a message at this number? ☐ Yes ☐ No | |

| EMERGENCY CONTACT (Last Name, First Name) | PHONE NUMBER |
|---|---|
| | |

**How did you learn about the program?** ☐ Internet ☐ Magazine: ☐ Newspaper ☐ Television ☐ Other:

**Did a physician or other patient recommend us?** ☐ No ☐ Yes (If yes, please provide name):

From time to time, we may wish to send you information or special offers that we may feel may be of interest to you regarding our weight loss program. We may also contact you in relation to consumer research, marketing and customer surveys.

**Yes, I would like to receive such information & offers by:** ☐ **Postal Mail** ☐ **Phone** ☐ **Email** (check all that apply)

**PRIVACY:** Your information will be kept strictly confidential and not provided to any third parties.

**Insurance Notice**

Your insurance company may cover expenses related to weight management. However, reimbursement will not be made from your insurance provider to this office. This office will not submit any bills to your insurance provider for weight management services or related fees. At your request, we will provide you a receipt of payment for services. We are unable to assist you with explaining, completing, or submitting any forms that may be required by your insurance company.

**Are you currently a beneficiary of Medicare?** ☐ Yes ☐ No

If yes, Medicare may cover certain weight loss services and programs when it is a medical necessity. However, we are not participating providers of Medicare and do not accept assignment. Because of this, reimbursement will not be made from Medicare to this office. This office will not submit any bills to Medicare for weight management services or related fees. At your request, we will provide you a receipt of payment for services so that you may bill Medicare on your own for reimbursement. Regrettably, we are unable to assist you with explaining, completing, or submitting any forms that may be required by Medicare.

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## Weight History

| NAME | DATE |
|---|---|
| | |

| | |
|---|---|
| When did you first become overweight? | How long have you been trying to lose? |
| What has been your heaviest weight? | When were you that weight? (record your age) |

Have you ever stayed the same weight for ten (10) years or more? Yes No

What do you think is the main cause of your weight problems?

Describe your previous attempts with dieting or weight loss. Include dates and results if possible.

Are any other members of your household overweight? No

Yes If yes, please list relation and details:

**What is your motivation for treatment in our weight loss & wellness program?**
Check all that apply.

- Don't like the way I look
- More energy
- Better work opportunities
- More mobility
- Attend a wedding/graduation
- Reduce Pain
- Perform better
- Clothes don't fit anymore
- Improve health
- Feel better
- Want to wear smaller sizes
- Detoxify the body
- Look better
- Live longer
- Increase self confidence
- Lower blood pressure
- Look & feel younger
- Control blood sugar levels
- Reduce medications
- other (please describe):

**What is your exercise routine?**
Check all that apply.

- Walking
- Swimming
- Dancing
- other (please describe):
- Pilates
- Stairmaster
- Bicycling
- Yoga
- Sports (basketball, tennis, etc.)
- Strength training
- Elliptical
- Treadmill / Jogging

**How often do you exercise?** Never Rarely Daily 4-5 Times a week 2-3 Times weekly Once a week

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# Medical History

| **Patient Name:** | | **Date:** | |
|---|---|---|---|

| **Family History (If blood relative has suffered the following, please indicate relationship.)** | | | |
|---|---|---|---|
| Heart Attack | | Arthritis | |
| Cancer | | Diabetes | |
| Hypertension | | Obesity | |
| Stroke | | Glaucoma | |
| Epilepsy | | Other | |

| **Have you ever been hospitalized? If yes, when and why?** | |
|---|---|
| **Year** | **Illness or Operation** |
| | |
| | |
| | |

**Medications (Please list the medications you are currently taking, and as needed.)**

| **Medication** | **Dosage** | **How Often** | **Reason** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Supplements (Please list the supplements you are currently taking, i.e. vitamins, fish oil, etc...)**

| **Supplement & Brand Name** | **Dosage** | **How Often** | **Reason** |
|---|---|---|---|
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| | | | |
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**Allergies (Please list any medications or food that you are allergic to.)**

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| |

**Medical History** (Check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Loss of hearing | | Swollen ankles | | Memory loss | | Alcohol abuse |
| | Ringing in ears | | Chest pain | | Insomnia | | Drug abuse |
| | Ear infections | | Loss of appetite | | Nervousness | | Hypertension |
| | Bad vision | | Indigestion | | Depression | | Heart disease |
| | Glaucoma | | Stomach ulcers | | Phobias | | Thyroid disease |
| | Nose bleeds | | Diarrhea | | Manic depressive | | Cancer |
| | Sinus trouble | | Constipation | | Anxiety | | Diabetes |
| | Sore throat | | Bloody/tarry stools | | Schizophrenia | | Stroke |
| | Allergies | | Hemorrhoids | | Bulimia | | Osteoporosis |
| | Hoarseness | | Hernia | | Anorexia | | GERD |
| | Pneumonia | | Gall bladder | | Other eating disorders | | Rashes |
| | Bronchitis | | Sudden weight loss | | Frequent urination | | Chicken pox |
| | Asthma | | Liver disease | | Kidney disease | | Mumps/measles |
| | Short of breath | | Back pain | | Prostate disease | | Polio |
| | Tuberculosis | | Joint pain | | Headaches | | Are you pregnant? |
| | Heart murmur | | Broken bones | | Fatigue | | Could you be Pregnant? |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Palpitations | | Dizzy spells | | Anemia | | Are you breast feeding? |
| | Irregular pulse | | Fainting spells | | Immune disorders | | Other: |

☐ **Yes** # Wellness Questionnaire

| **Patient Name:** | | **Date:** | |
|---|---|---|---|

| | | |
|---|---|---|
| ☐ | **No** | Do you feel groggy and not refreshed when you wake up? |
| ☐ | **No** | Do you have trouble falling asleep or staying asleep? |
| ☐ | **No** | Do you have trouble concentrating? |
| | **No** | Do you get headaches? |
| | **No** | Do you feel fatigued after exercise? |
| ☐ | **No** | Do you often feel stressed? |
| ☐ | **No** | Do you experience fatigue? |
| ☐ | **No** | Do you carry weight around the middle? |

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**Notes and Recommendations** (Medical Staff Only)

# Appetite Suppressant and Weight Loss Consent

I hereby authorize Dr. Mackay and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise program, and lifestyle changes. I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. Appetite suppressants labeling suggestions are based on short-term studies of 12 weeks. The experience of Bariatric physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements and injections are effective for longer than 12 weeks.

Dr. Mackay and associates believe in the off label use of medications proven to be effective in medical studies to promote weight loss and in the use of nutritional supplements and injections. These injections, nutritional supplements and medications can help you lose weight faster and make you feel better while you are losing weight. These nutritional supplements, injections and medications can boost your energy, burn fat faster, and eliminate cravings. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise and or eat fewer calories. Dr. Mackay and associates disagree with this simplistic thinking, and believes that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

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 or an exchange-eating program without the use of the appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heart beat, and heart irregularities. Less common, but more serious risks are valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that there are risks associated with obesity. Among these risks are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, hips, knees, and feet. I also understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop significant gallbladder disease during their lifetime. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible.

There is no guarantee that the program will work for me. By consenting to treatment I agree to pay in full for all visits and charges at the time of each visit. **I understand that your services are not reimbursed by insurance, and that you do not provide or fill out claim forms for insurance purposes.** I understand that no refunds are

ever given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience; however, I may request that a prescription be written for the weekly dose of the medication.

I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Dr. Edward G. Mackay or this office's physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications.

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

My signature further confirms that I do not have a current history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. My signature also confirms that if I have a past history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, I have fully disclosed this information in my medial history, since these conditions constitute a contraindication to the use of appetite suppressants.

By signing below I certify that I have read and fully understand this consent form. **I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction.**

I further understand that Dr. Edward G. Mackay Weight Management Program and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non- exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

**My signature below indicates my consent of treatment.**

Patient: Date:

Witness:

**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 alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient had consented to therapy involving the appetite suppressants.

Physician's Signature: Date:

# Patient Acknowledgement of Office Policies

**Please initial each item**

If indicated, a prescription will be written at each office visit. I may elect to have the medication dispensed on premise, or have the prescription filled at any pharmacy.

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I understand that services are not reimbursed by insurance and that the office does not provide or fill out claim forms for insurance purposes.

I understand that payment is due at the time services are rendered.

I understand that I must cancel my appointment within 24 hours prior to my scheduled appointment if I am unable to make it to the office.

_____

I understand that failure to cancel my appointment within 24 hours prior to my scheduled appointment will result in the posting of a $35.00 cancellation fee to my account.

_____

I understand that all returned checks will be subject to any applicable bank fees, as well as, any applicable collection legal fees.

_____

I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

My signature below and initials above indicate that I have read and understand and I agree to comply with all the above.

Signature of Responsible Party Date

# Photographs Consent Form

I DO , DO NOT (Please initial one) hereby authorize Dr. Edward G. Mackay Weight Management Program staff to take my fully clothed photograph during my initial consultation, during, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and are kept in my chart at all times.

I DO , DO NOT (Please initial one) give permission for my photographs to be used by Dr. Edward G. Mackay Weight Management Program for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

Patient: Date:

Witness: Date:

For office use only

# Receipt of Notice of Privacy Practices Written Acknowledgement Form
# &
# Authorization for the use of Disclosure of Individually Identifiable Health Information to Business Associates of Dr. Edward G. Mackay

I, , have received a copy of
Patient Name

Dr. Mackay's Weight Management Program's Notice of Privacy Practices.

Signature of Patient Date

# Patient authorization for disclosure of protected health information

I, , D.O.B. ,

SS# , authorize Dr. Mackay and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name:

Name:

Name:

Name:

Signature Date

Witness Date