ATTENTION:

Please be aware according to FL Statutes. We must do re-evaluations at least every 3 months to stay compliant by the following guidelines mandated by the state of Florida.

64B8-9.012 Standards for the Prescription of Obesity Drugs.

The prescription of medication for the purpose of enhancing weight loss should only be performed by physicians qualified by training and experience to treat obesity. All licensees are expected to abide by the following guidelines and standards in the utilization of any drug, any synthetic compound, any nutritional supplement, or herbal treatment, for the purpose of providing medically assisted weight loss.

(1) To justify the use of weight loss enhancers as set forth above, the patient must have a Body Mass Index (BM!) of 30 or above, or a BM! of greater than 27 with at least one comorbidity factor, or a measurable body fat content equal to or greater than 25% of total body weight for male patients or 30% of total body weight for women. The prescription of such weight loss enhancers is not generally appropriate for children. Any time such prescriptions are made for children, the prescribing physician must obtain a written informed consent from the parent or legal guardian of the minor patient in addition to complying with the other guidelines and standards set forth in this rule. BM! is calculated by use of the formula BMI= kg/m.

(2) Physicians in Florida are prohibited from prescribing, ordering, dispensing, or administering any weight loss enhancer that is both a serotonergic and anorexic agent unless the drug has been approved by the Food and Drug Administration (FDA) specifically for use in weight loss management. Selective serotonin re-uptake inhibitors (SSRIs} that have not been approved by the FDA for weight loss may not be prescribed, ordered, dispensed, or administered for such purposes.

(3) An initial evaluation of the patient shall be conducted prior to the prescribing, ordering, dispensing, or administering of any drug, synthetic compound, nutritional supplement or herbal treatment and such evaluation shall include an appropriate physical and complete history; appropriate tests related to medical treatment for weight loss; and appropriate medical referrals as indicated by the physical, history, and testing; all in accordance with general medical standards of care.

(a) The initial evaluation may be delegated to an appropriately educated and trained physician's assistant licensed pursuant to Chapter 458, F.S., or an appropriately educated and trained advanced registered nurse practitioner licensed pursuant to Chapter 464, F.S.

(b) The initial evaluation required above is delegated to a physician's assistant or to an advanced registered nurse practitioner, then the delegating physician must personally review the resulting medical records prior to the issuance of an initial prescription, order, or dosage.

(4) Prescriptions or orders for any drug, synthetic compound, nutritional supplement or herbal treatment for the purpose of assisting in weight loss must be in writing and signed by the prescribing physician. Initial prescriptions or orders of this type shall not be called into a pharmacy by the physician or by an agent of the physician. Even if the physician is registered as a dispensing physician, a hard copy of the written prescription must be maintained in the patient's medical records for each time such weight loss **enhancers are prescribed, ordered, dispensed, or administered.**

(5) At the time of delivering the initial prescription or providing the initial supply of such drugs to a patient, the prescribing physician must personally meet with the patient and personally obtain an appropriate written informed consent from the patient. Such consent must state that there is a lack of scientific data regarding the potential danger of long term use of combination weight loss treatments and shall discuss potential benefits versus potential risks of weight loss treatments. The written consent must also clearly state the need for dietary intervention and physical exercise as a part of any weight loss regimen. A copy of the signed informed consent shall be included in the patient's permanent medical record.

(6) Each physician who is prescribing, ordering. or providing weight loss enhancers to patients must assure that such patients **undergo an in-person re-evaluation within 2 to 4 weeks of receiving a prescription, order, or dosage. The reevaluation shall include** the elements of the initial evaluation and an assessment of the medical effects of the treatment being provided. Any patient that continues on a drug, synthetic compound, nutritional supplement or herbal treatment assisted weight loss program shall be re- evaluated at least once every 3 months.

(7) Each physician who prescribes, orders, dispenses, or administers any drug, synthetic compound, nutritional supplement or herbal treatment for the purpose of assisting a patient in weight loss shall maintain medical records in compliance with Rule 64B8- 9.003, F.A.C., and must also reflect compliance with all requirements of this rule.

(8) Each physician who prescribes, orders, dispenses, or administers weight loss enhancers for the purpose of providing medically assisted weight loss shall provide to each patient a legible copy of the Weight-Loss Consumer Bill of Rights as set forth in Sections 501.0575(1)(a} through (e)3. F.S. The physician shall also conspicuously post said document in those rooms wherein patients are evaluated for weight loss treatment.

(9) Any physician who advertises practice relating to weight loss or whose services are advertised by another person or entity.

Patient's Signature _____ Date _____

PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Cellular Phone: _____ **Home or Alternate Phone**: _____

Date of Birth: _____ Age: _____ Sex: M F

Social Security: _____Driver's License: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No: _____Ext. _____

How Did You Hear About Us:

☐ Internet ☐ Email ☐ Location/Sign ☐ Phonebook ☐ Other (please specify)_____

☐ Doctor Referral (please specify who so we can send a Thank You)_____

☐ Patient Referral (please specify who so we can send a Thank You)_____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

FINANCIAL POLICY

Thank you for selecting Doctor Rx Weight Loss, L.L.C. for your health care 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 the time services are rendered. For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express and Discover.

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's Signature _____ Date _____

MEDICAL HISTORY FORM

Name: _____ Age:_____ Sex: M F

Family Physician: _____ Phone: _____

Present Status:

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

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes No
   What: _____ Dosages: _____
   What:_____ Dosages: _____

4. Any allergies to any medications? Yes No
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Serious Injuries: Yes No
    Specify: _____ Date: _____

13. Any Surgery: Yes No
    Specify: _____ Date: _____

    Specify: _____ Date: _____

14. Family History:

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

15. Hormone Replacement Therapy: Yes No
What: (current, past) _____

Has any blood relative ever had any of the following:

Glaucoma:	Yes	No	Who: _____
Asthma:	Yes	No	Who: _____
Epilepsy:	Yes	No	Who: _____
High Blood Pressure	Yes	No	Who: _____
Kidney Disease:	Yes	No	Who: _____
Diabetes:	Yes	No	Who: _____
Tuberculosis:	Yes	No	Who: _____
Psychiatric Disorder	Yes	No	Who: _____
Heart Disease/Stroke	Yes	No	Who: _____

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ 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
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____

FEMALES ONLY

Gynecologic History:

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset: _____ Duration: _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____ Regular Irregular

Last mammogram Date:_____ Normal: Yes No

Last PAP Smear Date:_____ Normal: Yes No

Hysterectomy Date:_____ Ovaries Removed: Yes No

Birth Control Pills: No Yes Type of Birth Control: _____

Last Gynecology Check Up: _____

MALES ONLY

Last prostate exam Date:_____ Normal: Yes No

Last PSA lab work Date:_____ Normal: Yes No

NUTRITION EVALUATION

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (give reasons, if known): _____

   _____
6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: Give dates and results of your weight loss:

   _____ _____

   _____ _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. If yes, by how much is he/she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent? _____
12. How often do you eat "fast foods?" _____
13. Who plans meals? _____ Cooks? _____ Shops? _____
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you shop for groceries? _____
16. Food allergies: _____
17. Food dislikes: _____
18. Food you crave: _____
19. Any specific time of the day or month do you crave food? _____
20. Do you drink coffee or tea? Yes No How much daily? _____
21. Do you drink cola drinks? Yes No How much daily? _____
22. Do you drink alcohol? Yes No
    What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

    What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

    What? _____ How much? _____ When? _____

    _____ _____ _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

    _____

    _____

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

    _____

    _____

29. Smoking Habits: **(answer only one)**

    - ❑ You have never smoked cigarettes, cigars or a pipe.
    - ❑ You quit smoking _____ years ago and have not smoked since.
    - ❑ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
    - ❑ You smoke 20 cigarettes per day (1 pack).
    - ❑ You smoke 30 cigarettes per day (1-1/2 packs).
    - ❑ You smoke 40 cigarettes per day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: **(answer only one)**

- ❑ Inactive – no regular physical activity with a sit-down job.
- ❑ Light activity – no organized physical activity during leisure time.
- ❑ 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.

33. 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.

34. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

35. Do you filter your drinking water? Yes No

36. Do you ionize your drinking water? Yes No

37. Do you have full spectrum lighting in your home/office? Yes No

38. Do you use your computer or mobile phone late in the evening? Yes No

39. Are you exposed to EMF's at home or work (i.e. computers, cellphones, electronic devices, microwave, etc.)? Yes No

40. Do you get 6.5 to 8 hours of sleep per night? Yes No

41. Do you filter the air in your office or home? Yes No

42. Do you ionize the air in your office or home? Yes No

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.

F E M A L E S O N L Y

Rx Weight Loss Hormone Health Checklist for Women

Below are a few of the more common symptoms caused by hormonal imbalances.
Please answer the following questions to help us evaluate your hormonal system.

Which of the following symptoms apply to you currently (in the last 2 weeks)?
Please mark the appropriate box for each symptom. For symptoms that do not currently apply, mark "never."

Patient Name: _____ DOB :_____ DATE: _____

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)					
Sleep Problems (difficulty falling asleep, staying asleep, waking up tired)					
Hot Flashes					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Physical exhaustion (decrease in muscle strength or endurance, fatigue, lack of energy, stamina, or motivation)					
Anxiety (inner restlessness, feeling panicky, feeling nervous)					
Sexual problems (change in sexual desire or orgasm satisfaction)					
Bladder problems (difficulty urinating, increased need to urinate, incontinence)					
Vaginal Symptoms (dryness/burning or difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain/swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating, or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places, or things					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning, or change in texture of hair					
Feel cold all of the time, cold hands					
Weight gain, increased belly fat, or difficulty losing weight					
Dry or wrinkled skin					
TOTAL					

Severity	Score
Mild	1 – 20
Moderate	21 – 40
Severe	41 – 60
Very Severe	61 – 80

MALES ONLY

Rx Weight Loss Hormone Health Checklist for Men

Below are a few of the more common symptoms caused by hormonal imbalances.
Please answer the following questions to help us evaluate your hormonal system.

Which of the following symptoms apply to you currently (in the last 2 weeks)?
Please mark the appropriate box for each symptom. For symptoms that do not currently apply, mark "never."

Patient Name: _____ DOB :_____ DATE: _____

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)					
Sleep Problems (difficulty falling asleep, staying asleep, waking up tired)					
Increased need for sleep or falls asleep easily after meal					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Physical exhaustion (decrease in muscle strength or endurance, fatigue, lack of energy, stamina, or motivation)					
Anxiety (inner restlessness, feeling panicky, feeling nervous)					
Sexual problems (change in sexual desire or orgasm satisfaction)					
Bladder problems (difficulty urinating, increased need to urinate, incontinence)					
Erectile changes (less strong erections, loss of morning erections)					
Joint and muscular symptoms (joint pain/swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating, or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places, or things					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning, or change in texture of hair					
Feel cold all of the time, cold hands					
Weight gain, increased belly fat, or difficulty losing weight					
Infrequent or absent ejaculations					
TOTAL					

Severity	Score
Mild	1 – 20
Moderate	21 – 40
Severe	41 – 60
Very Severe	61 – 80

PATIENT CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

I_____ (patient or patient's guardian) authorize Dr Ford of Doctor Rx Weight Loss, L.L.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.

1. I have read and understand my doctor's statements that follow:

"Medication, 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 suppressants labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger does than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggest, 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 physician, 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 risk of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

2. I understand it is my responsibility to follow the instructions carefully and to report to the doctor 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.

3. 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.

4. 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 appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risk of Proposed Treatments:

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 heartbeat and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and vascular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risk Associated with Being Overweight or Obese:

I am aware the there are certain risk associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and no 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 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 QUESTION 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. 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 continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's Signature_____

WEIGHT LOSS PROGRAM POLICY

I understand that if I develop any side effects from the Doctor Rx Weight Loss, L.L.C program, I will stop the diet and/or medication and notify the doctor at Doctor Rx immediately. If the problem is severe, I will go to the Emergency Room immediately.

There is no guarantee the program will work for me you. By signing below, you certify you have read and fully understand this consent form. You should not sign this form if you have any questions or concerns that have not been answered to your complete satisfaction. Your signature further confirms that you do not have a history of alcohol abuse, drug abuse, schizophrenia, or manic-depressive illness or a history of any eating disorder since these conditions are a contradiction to the use of appetite suppressants. You agree not to take any other appetite suppressants, other medications or injections other than those prescribed by the Doctor Rx doctor or listed and approved on your medical history form. You will inform the doctor of any change in your medication.

I understand that the Doctor Rx Weight Loss program, all written materials describing the program or any of its parts, applicable trademarks, copyrights and other intellectual property in or our program are and remain our absolute property. You acknowledge that you are purchasing a non-exclusive, non transferable license to use our program and the related written materials for your own use, and that you have no right to duplicate or to sell, lend or transfer in any way to any other person the use of our program or written materials.

Again, thank you for selecting Doctor Rx Weight Loss for your health care 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 the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, checks and cash. You understand that our services are not reimbursed by insurance, and we do not provide or fill out claim forms for insurance. 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. You also understand that no refunds will be given at any time for any reason. I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

_____

Witness

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information." Please Review It Carefully.

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of the computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and billing personnel. We may use your medical information for treatment and care, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses), billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, products recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provide authorization is IRB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief and fundraising

We will not use or disclose your medical information for any purpose not listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

PATIENT PRIVACY RIGHTS

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your information to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of the notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can complain about our privacy policy or its execution either verbally or in writing to our office. If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services. Effective Date: April 14, 20003

PRIVACY NOTICE RECEIPT

I have read and/or requested a copy of Doctor Rx Weight Loss privacy notice as required by HIPPA.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

RELEASE OF MEDICAL RECORDS

I give permission for my medical records (blood work, chart, EKG) to be released to:

DOCTOR RX WEIGHT LOSS, L.L.C

2828 SOUTH TAMIAMI TRAIL

SARASOTA, FL 34239

PHONE (941) 957-0200

FAX (941) 953-7883

Patient's Printed Name: _____

Patient's Signature: _____

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. Consult your personal physician before starting any 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; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

Patient's Signature	Date

WEIGHT LOSS PROGRAM CONSENT FORM

I _____ authorize Dr. Robert E. Ford & Doctor Rx Weight Loss, L.L.C and whomever they designate as their assistants, 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 supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me 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 any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

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 urged and 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 your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(Or person with authority to consent for patient)

F E M A L E S O N L Y

FEMALE TESTOSTERONE AND/OR ESTRADIOL PELLET INSERTION CONCENT FORM

Name: _____
(Last) *(First)* *(Middle)*

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles. Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by selecting OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets. Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: *(circle one)*

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my buttock. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks:** Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); increase in hair growth on the face, similar to pre-menopause patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and/or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____
(Patient's Signature)

M A L E S O N L Y

GENERAL MALE CONCENT FORM FOR TESTOSTERONE THERAPY

Name: _____
(Last) *(First)* *(Middle)*

Bio- identical testosterone pellets are hormones biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause". Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio identical hormone pellets are plant derived and bio-identical hormone replacement using pellets has been used in Europe, the U.S, and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During Andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Risks of not receiving testosterone therapy after andropause include but are not limited to: Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increase overall inflammatory processed, dementia and Alzheimer's disease, and many other symptoms of aging.

Consent for Treatment: I consent to the insertion of testosterone pellets and I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

Side Effects may include: Bleeding, bruising, swelling, infection, pain, reaction to local anesthetic and/ or preservatives, lack of effect, thinning hair, male pattern baldness, increased growth of prostate or prostate tumor, extrusion of pellets, hyper sexuality, decrease in size of testicles, and reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow up with an U/S of the prostate may be required as well as a referral to a qualified specialist for evaluation. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually. This condition can be reverses simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well -being: increased muscle mass and strength and stamina: decreased frequency and severity of migraine headaches: decrease in mood swings, anxiety, and irritability (secondary to hormone decline); decreased weight (increase in lean body mass); decrease in risk of diabetes; decreased risk of Alzheimer's and dementia; and decreased risk in heart disease in men less than 75 years old with no pre- existing history of heart disease.
On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, creams, and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance may not reimburse me, depending on my coverage. I acknowledge that RX weight loss has no contracts with any insurance companies and is not contractually obligated to pre-certify treatment with my insurance company or letters of appeal.

_____
(Patient's Signature)

DISCLOSURE LIABILITY WAIVER
Bioidentical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bioidentical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit and is being used at our office to lessen /treat non-life-threatening symptoms you may have identified as bothersome, undesirable and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bioidentical hormonal replacement regimens, and the use of any medications and/or supplements is untaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from RX Weight Loss, its staff or treating providers for injury to you on account of involvement in the Bioidentical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

Patient's Name: _____

Patient's Signature: _____

Date: _____

MAINTENANCE OF PREVENTATIVE MEDICINE & CANCER SURVEILLANCE

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, Mammogram, Prostate exam and regular PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening form your primary care physician within 3 months of beginning the Bioidentical Hormone replacement Therapy program and then according to current guidelines, which can be obtained, and followed with your primary care /gynecologist.

Patient's Name: _____

Patient's Signature: _____

Date: _____

MAMMOGRAM WAIVER HORMONE THERAPY

I, _____ voluntarily choose to undergo treatment with hormone therapy to possibly include estradiol, progesterone, and testosterone, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that hormone replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking hormone therapy could possibly stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on hormone therapy.

For today's appointment I DO NOT have a mammogram for the following reason:

( ) It is my decision not to have one.

( ) I'm unable to provide the report at this time. My last mammogram was ____/_____/_____.

( ) It is my doctor's decision not to have one.

Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram. I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive hormone therapy.

_____(initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo hormone therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Doctor RX Weight Loss, LLC any of their medical providers, nurses, officers, directors, employees, and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____	_____	_____
Print Patient's Name	Patient's Signature	Date

_____	_____
Provider Signature	Date

CONFIDENTIALITY AGREEMENT

The undersigned reader acknowledges that the information provided herein pertaining to Doctor Rx Weight Loss, LLC in this business plan is confidential; therefore, reader agrees not to disclose it without the express written permission of Doctor Rx Weight Loss, LLC.

It is acknowledged by reader that the information to be furnished in this business plan is in all respect confidential in nature, other than information which is the public domain through other means and that any disclosure or use of same by reader, may cause serious harm or damage to Doctor Rx Weight loss, LLC.

Upon request, this document is to be immediately returned to Doctor Rx Weight Loss, LLC.

_____ _____

Patient's Signature Witness

Revised 10/22/21 - KM