Envizion Medical

Date:_____

NEW PATIENT PACKET

First Name: _____ **Last Name:** _____ **DOB:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Gender:** _____ **Marital Status:** _____

Social Security #: _____ **(FOR HRT PATIENTS ONLY) Insurance Provider:** _____

What are your goals/reason for visit? _____

	YES	NO	How much?
Do you smoke Cigarettes/Cigars/Tobacco?			
Do you drink alcohol? How often?			
Do you drink Coffee? How Much?			
Do you drink Water? How Much?			

Occupation:_____

Please circle from 1-10 the stress level of your occupation

1	2	3	4	5	6	7	8	9	10

Laid Back **Stressed**

OPERATIONS, SURGICAL PROCEDURES: _____

_____

SERIOUS INJURIES OR ILLNESS: _____

ALLERGIES TO MEDICATIONS OR FOODS: _____

ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER AND HORMONES: _____

_____

_____

ARE YOU CURRENTLY TAKING COUMADIN? _____

HOW WERE YOU REFERRED TO OUR CLINIC? _____

HAVE YOU VISITED OUR WEBSITE? _____

ARE YOU CURRENTLY TAKING SUPPLEMENTS? _____

_____

_____

Groupon Voucher Number: _____ Redeemed by: _____

Family and Medical History

	Myself	Sibling	Parents		Myself	Sibling	Parents
Cancer				High Blood Pressure			
Diabetes				Lung Disease			
Heart Disease/Hypertension				Kidney Disease			
Arthritis				Weight Control			
Liver Disease				Anemia			
Elevated Cholesterol/Triglycerides				Alcohol Abuse			
Endocrine Abnormalities				Drug Abuse/Recreational			

Males and Females please answer the following about your personal symptoms

	Always	Sometimes	Never		Always	Sometimes	Never
Low Mood/Depression				Weight Loss			
Irritability/Anxiety				Weight Gain			
Anger/Aggression				Increased Fat on stomach			
Decreased Motivation				Caffeine/Stimulant Cravings			
Decreased Productivity				Digestive problems			
Concentration Problems				Hair Loss			
Memory/Foggy Thinking				Dry Skin/Thinning Skin			
Increased fatigue				Lowered Libido			
Decrease in strength/Stamina				Erectile Dysfunction			
Decrease in Athletic performance				Binge Eating			
Decreased lean muscle mass				Skips Meals			
Body/Joint aches				Sweet Cravings			

Females Only:	YES	NO		YES	NO
Night Sweats			Menstrual Problems		
Wake up in the middle of night			Premenstrual Tension		
Endometriosis			Infertility		
Vaginal Dryness			Inability to reach orgasm		
Lack of sexual desire			Breast Tenderness		

Males Only:	**YES**	**NO**		**YES**	**NO**
Prostate Problems			Unable to get erection		
Inability to ejaculate			Lack of sexual desire		
Other testicular Problems			Vasectomy		

Additional Problems: _____

_____

PATIENT CONSENT TO ALL ENVIZION MEDICAL SERVICES Please initial, indicating you understand and agree with the following statements:

____ I understand that a voucher from any and all outside company's such as Living Social may only be used on my first visit to the clinic. I understand that if I purchase another voucher it is my responsibility to get a credit back from the third party. The office staff will be unable to accept this voucher. All additional months of services are owned in full to Envizion.

____ The number of patients we see is limited by appointment only. Missed appointment's cause an inconvenience to other patients. Please notify us twenty-four hours in advance if you are unable to keep your appointment.

____Most health insurance companies typically do not provide coverage for medically monitored weight-loss and Bio-Identical Hormone Therapy. Therefore, we do not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, check, or credit card.

____I understand that some of the treatments suggested for me are as yet unproven and experimental, however, I have been informed of this, and I am willing to accept the risks on the basis of the information provided to me. I will have an opportunity to ask questions and to research any treatment suggested before I agree to do it. I understand that the doctors have done their research as well, including, (in most cases) have taken these treatments themselves.

____I understand any treatments rendered through Envizion Medical are solely for The purpose of hormone balancing/restoration, body-fat reduction, and preventative Medicine. We are not capable of serving as your primary care facility. If I become ill, I Should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or weight-loss medication from this clinic until it is determined safe to Resume the weight control program.

____I understand that NO PRESCRIPTION WILL BE PROVIDED UNLESS A CLINICAL NEED EXIST BASED ON REQUIRED LAB WORK, PHYSICIAN CONSULTATION, PHYSICAL EXAMINATION AND/OR CURRENT MEDICAL HISTORY. PLEASE NOTE, AGREEING TO LAB WORK AND PHYSICAL EXAM DOES NOT AUTOMATICALLY EQUATE TO A PRESCRIPTION.

NOTICE OF PRIVACY PRACTICES:
THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
SUMMARY: By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to confidential communications
5. The right to report a disclosure of your information
6. The right to a paper copy of this form

We want to assure you that your medical/protected health information is secure with us. If you have any questions regarding this form please contact one of the office staff at Envizion.
I hereby acknowledge that I have received a copy of these practices NOTICE OF PRIVIACY PRACTICES. I understand that if I have a question or complaint regarding my privacy rights that I may contact a member of the staff at Envizion. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient Name (Please Print) _____ Patient Signature/Date _____

HORMONE REPLACEMENT ONLY

____I hereby request and consent to the administration of Hormone Therapy and/or nutritional supplements by my physician at Envizion Medical for the purpose of restoring optimal levels, even where lab test results are within reference ranges for age and/or in circumstances where other medical organizations do not recommend the same.

____ I have been advised and do understand all the risks and possible complications of Hormone Replacement Therapy, as well as noncompliance with Envizion Medicals physicians recommended dosage. I further agree to administer all medications as directed by our physicians at Envizion Medical.

____ I agree to immediately report to Envizion Medical staff any adverse reactions or problems, of whatever nature, whether or not said matters relate to BHRT treatment.

____I understand that restoring and balancing hormones accurately requires follow up blood work and monitoring. These follow-ups may require additional costs for the patient. If I fail to submit to requested follow-ups I understand that my physician, at his/her discretion, will discontinue my therapy until requested information is received.

____ I understand that I will not contact the pharmacy who fills my prescriptions about billing or insurance related questions or I will be discharged from Envizion Medical. If I have any drug interactions I will call Envizion Medical first who will then direct me to the pharmacy.

____I understand that Envizion Medical is not responsible for any lost or stolen packages that are delivered. I understand that a $6.00 signature required fee is available upon request.

____ I understand that I am responsible for updating any permanent or temporary address changes to Envizion Medical.

I have read, understand and agree to all of the above statements. Patient signature_____

Staff Signature/Date_____

FOR WEIGHT LOSS PATIENTS ONLY - PHENTERMINE INFORMED CONSENT

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have it ordered through Dr. I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. Dr. can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand Dr. can only prescribe Phentermine and medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

Initials: _____

Contraindications and Warnings

Patients with the following **should not** use Phentermine:

- An allergy to Phentermine
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or glaucoma
- Are in an agitated state or have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant

Patients with the following **should take special precautions** and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or high cholesterol or lipid levels

Side Effects

While Phentermine is generally free of negative side effects, there is the *possibility* of the following:

- Dry mouth
- Diarrhea
- Nausea/ Vomiting
- Unpleasant taste
- Constipation
- Fatigue
- Heartburn
- Stomach Pain
- Hypertension
- Skin Rash or Itching
- Lactic acidosis
- Insomnia or Restlessness

Less common side effects include:

- Convulsions (Seizures)
- Erectile Dysfunction
- Depression
- Panic attacks
- Fever
- Hallucinations
- Tremors or shaking
- Fainting
- Overactive reflexes

I understand Phentermine treatments may involve these risks and other unknown risks:
Initials: _____

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments.
Initials: _____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this.
Initials: _____

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact Dr. immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility.
Initials: _____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise Dr. at that time.
Initials: _____

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times.
Initials: _____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient's Name Signature: _____ Provider's Name Signature:_____