NP Hagans Hagans Walk-In Clinic Weight Loss Registration Form
9135 Piscataway Road # 320 Clinton, MD 20735* (240) 412-5093

Patient Information

First Name	Middle Initial	Last Name	Date of Birth
Street Address	City	State	Zip Code
Home Phone Number	Work Phone	Cell Phone	Email Address

Emergency Contact

Name	Phone Number	Relation to Patient

Please answer the following questions:

Are you Pregnant or Breastfeeding?	Yes	No
Do you have a medical history of Depression, Panic Disorder, Anxiety Disorder?	Yes	No
Are you currently taking medication for depression or anxiety?	Yes	No
Do you smoke cigarettes?	Yes	No
Do you drink alcohol?	Yes	No
Are you allergic to sulfur, methionine, inositol, choline, phentermine, or cyanocobalamin?	Yes	No

Previous Weight Loss Attempts

Please list previous diet plans, medications, or supplements you have tried in the past in order to lose weight.

_____

Allergies

Please list any allergies to medications or foods

Medications

Please list any medications you take including over the counter medications

Name	Dosage	Frequency

Health History

Do you currently have or had any of the following conditions?

Heart Disease	Yes	No
Heart Surgery	Yes	No
HIgh Blood Pressure	Yes	No
HIgh Cholesterol	Yes	No
Fatty Liver	Yes	No
Abnormal EKG	Yes	No
Osteoarthritis	Yes	No
Adrenal Fatigue	Yes	No
Sleep Apnea	Yes	No
Headaches/Migraines	Yes	No
Anorexia/Bulimia	Yes	No
Vitamin Deficiency	Yes	No
Glaucoma	Yes	No
Epilepsy	Yes	No
Kidney Disease or Kidney Failure	Yes	No
Liver Disease, or Elevated Liver Enzymes	Yes	No
Have you ever had a reaction to any stimulant drugs?	Yes	No
Thyroid Problems	Yes	No
Diabetes	Yes	No
Hypoglycemia (Low blood sugar)	Yes	No
Have you ever tested positive for Tuberculosis (TB)	Yes	No
Have you ever tested positive for HIV?	Yes	No
Heart Murmur or irregular heartbeat?	Yes	No
Do you use any drugs (Cocaine, Crack, PCP, Marijuana, or LSD)	Yes	No

Diet and Weight History

How many servings of fruits and vegetables do you have daily	
How many servings of meat do you have per day?	
How would you describe your diet?	Excellent Good Fair Poor
Have you changed your eating habits?	
What is your favorite snack?	
Do you snack during the day (i.e. vending machine, 7-11)?	
How late do you eat?	
How many glasses of water do you drink per day?	
Do you eat package foods?	
Do you tend to eat or snack more when you are stressed or concerned?	
Do you eat fast foods? If so, how many times per day or week	
Do you eat out at restaurants?	
How long have you been overweight?	
What is/has been you peak weight?	
What is your current height and weight?	
How many pounds would you like to weigh?	
How many pounds have you loss to date?	
How many times per week do you exercise?	

In signing this document, to the best of my knowledge, the information that I have provided in relation to my health is true. The provider treating me shall rely and act upon this information to make decisions about my weight loss plan.

_____ _____

Patient Signature Date

NP HAGANS WALK-IN CLINIC
CONSENT TO TREAT, MEDICAL WAIVER, AND RELEASE OF INFORMATION
Health Insurance Portability & Accountability Act (HIPPA) of 1996 REQUIREMENT

The undersigned authorizes NP Hagans Walk-In Clinic to furnish medical treatment and the performance of those procedures which are considered necessary and proper in the treatment of the patient identified on this form. I hereby authorize NP Hagans Walk-In Clinic to furnish all my insurance companies, and my employer, any information which they may request, including photocopies from my medical records as necessary for completion of my claim, or as may be required by law for this treatment. I further authorize NP Hagans Walk-In Clinic to furnish information from my medical records pertaining to this treatment as requested by other physicians or medical care facilities such as, extended care facilities, intermediate care facilities, hospitals, or home health agencies for my continued care and treatment.

I,_____, authorize NP Hagans Walk-In Clinic to release my medical information for my treatment to the additional person(s) below:

_____ _____
Name Relation

For the specific types of communications listed below, circle the YES or NO to indicate which you give us permission to use:

1. YES NO Leave messages/results for you on an answering machine at home.
2. YES NO Leave messages/results with specific family member_____(family member name/relation)
3. YES NO Leave messages/results on your private voice mail at work.
4. YES NO Leave messages/results on your cell phone voice mail

I understand that the medical records to be released may contain all of my current and past medical history, diagnoses, and treatments. In addition, information related to HIV/AIDS status, sexually transmitted diseases, alcohol or drug use, or mental health services and I hereby authorize the release of this information. This consent is valid for the date signed until revoked in writing by the patient.

_____ _____
Patient or Guardian Signature Date

LIPOTROPIC INJECTIONS INFORMED CONSENT TO TREAT AND WAIVER OF LIABILITY

I have been informed of the following:

- While all components generally have no side effects, doses must be taken at regular intervals.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people have experienced allergic reactions to the injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys. Some patients have been unable to control their urine and/or had diarrhea.
- The effects of lipotropic injections are temporary but maximize fat burning capabilities.
- Depression is another possible side effect.
- It has been reported that B12 can cause peripheral vascular thrombosis, itching, and a feeling of swelling in the body.
- Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pains.
- Lipotropic injections change the function of the digestive system temporarily. This can result in extreme exhaustion.
- Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.
- Vitamin B12 is contraindicated in Leber's hereditary optic neuritis, as it can cause blindness.
- Results vary by individual
- I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required. I understand that I'm not eligible for any type of refund once treatment has initiated.

WAIVER OF LIABILITY

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments. All my questions have been answered to my satisfaction. In consideration of my participation in this program, I agree, on behalf of myself, my assigns, executors, and heirs, to release and hold harmless The Curators of NP Hagans Walk-In Clinic/Cherise R. Hagans, CRNP and their trustees, officers, employees, and agents from any and all liability, damage, or claim of any nature whatsoever arising out of my participation from this program. I understand that NP Hagans Walk-In Clinic/Cherise R. Hagans, CRNP may not provide any accident or medical insurance. I have read and understand the terms of this document and agree to all terms and conditions. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement. I am of lawful age and legally competent to sign this waiver and release, and I have signed this document as my own free act.

_____	_____	_____
Patient Name (Printed)	Patient Name (Signed)	Date