ThinIQUE WEIGHT LOSS, ENERGY & WELLNESS

Personal Information:			
□ Mr. □Dr.	First Name:	Middle Initial:	Last Name:
Address:	City:	State:	Zip:
Gender: M	Birth Date:	Age:	Last 4 of social:
Email:	Mobile Number:		Home Phone:
Occupation:	Employer:	May we contact you by: **Mobile:** □YES □NO **Home:** □YES □NO **Email:** □YES □NO **Mail :** □YES □NO	
Current Weight:	Height:		

Emergency Contacts: *(You must list at least one person)*		
Name:	Relationship:	Number:
Name:	Relationship:	Number:

How did you hear about us:
□Newspaper □Drive-by □Living Social □Amazon □Groupon □Internet □Doctor Referral □TV □Billboard □ Radio □Door hanger □Grand Opening balloon □Friend/Family □Previous location
Who may we thank for referring you?

Medical History:			
Are you experiencing any fatigue?	□ Yes	□ No	□ Unsure
Have you had any muscle weakness or loss of muscle mass?	□ Yes	□ No	□ Unsure
Has your interest in sex (libido) and/or sexual activity declined?	□ Yes	□ No	□ Unsure
Do you have spontaneous erections (without medication or other aid)?	□ Yes	□ No	□ Unsure
Has your energy level or stamina declined?	□ Yes	□ No	□ Unsure
Have you lost self-confidence, motivation, or initiative?	□ Yes	□ No	□ Unsure
Have you experienced any decline in memory or concentration?	□ Yes	□ No	□ Unsure
Have you had sleep disturbances, problems breathing while you are asleep, or increased daytime sleepiness?	□ Yes	□ No	□ Unsure
Do you have mood swings or depression?	□ Yes	□ No	□ Unsure
Do you have any breast or nipple tenderness or enlargement?	□ Yes	□ No	□ Unsure
Have you lost any hair in the genital or underarm areas?	□ Yes	□ No	□ Unsure
Have you noticed any significant change in size of your testicles?	□ Yes	□ No	□ Unsure
Do you have periodic hot flashes or sweats?	□ Yes	□ No	□ Unsure

There will be NO refunds once services have been performed.

Previous Medical History:			
Have you ever had an abnormal PSA test (prostate specific antigen)?	☐ Yes	☐ No	☐ Unsure
Do you now, or have you ever taken, anabolic steroids? If yes, which ones? _____	☐ Yes	☐ No	☐ Unsure
Have you received testosterone supplementation before? If yes, when? _____ Dose_____ Results? _____	☐ Yes	☐ No	☐ Unsure
Have you ever been diagnosed with liver or kidney disease, diabetes, high blood pressure, elevated cholesterol, sleep apnea, prostate issues, or acne as an adult? (If yes, circle which one)	☐ Yes	☐ No	☐ Unsure
Do you have any allergies to medications? If yes, please list below: _____	☐ Yes	☐ No	☐ Unsure
Do you currently take any prescription medicines, over-the-counter medicines, and/or supplements on a regular basis? If yes, please list: _____ _____	☐ Yes	☐ No	☐ Unsure
Have you had surgery in your genital area (such as vasectomy, testicle surgery, or prostate surgery? If yes, what procedure and what year? _____	☐ Yes	☐ No	☐ Unsure
Are you and your partner/spouse planning to seek pregnancy?	☐ Yes	☐ No	☐ Unsure

Family History:			
Are you aware of any blood relatives who have/have had prostate or breast cancer? If yes, please indicate which illness and how the person is related to you:	☐ Yes	☐ No	☐ Unsure

Exercise (frequency and type):			
	Never		Endurance (walking, jogging, playing sports, swimming, or climbing hills or stairs)
	Once a week		Strength (lifting weights or using a resistance band)
	2-4 times a week		Balance (standing on one foot, heel to toe walking, or tai chi)
	5-7 times a week		Flexibility (yoga)

Tobacco Intake:	
Do you use tobacco?	☐cigarettes ☐chew ☐pipe ☐cigars
Daily amount use of tobacco and for how long?	
Year you quit?	

Alcohol Intake:	
Do you drink alcohol?	
How many drinks per week?	☐ 1-2 ☐ 3-5 ☐ 5-10 ☐ None
What type of alcohol do you usually drink?	

Drug Use:	
Do you use street/recreational drugs?	
What type/how often?	
What year did you quit using drugs?	

Caffeine Intake:	
Caffeine intake daily	☐1-2 cups ☐3-5 cups ☐5-10 cups ☐None
What type of caffeine do you drink?	☐coffee ☐tea ☐soda ☐energy drinks

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Signed Consents:

Patient Lab Consent

I authorize the medical staff of Thinique Medical Weight Loss to obtain a blood sample for the following tests: Testosterone levels, PSA, Estradiol, Complete Blood Count (CBC), and Complete Metabolic Panel (CMP). The lab testing required by the program is included in the initial visit fee I paid OR may be billed to my insurance only if I have the blood drawn and testing performed at the laboratory named on the laboratory requisition given to me by the clinic. If I go to a different lab by my own choice or have the testing performed at a different facility other than that named on the requisition, **I WILL BE RESPONSIBLE FOR ANY AND ALL CHARGES AND FEES ASSOCIATED WITH THOSE LABS.** I understand that payment by my insurance depends upon my individual insurance coverage at the time of service. **I WILL BE RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT COVERED BY MY HEALTHCARE INSURER.** The risk involved in drawing blood from a vein may include, but are not limited to, momentary discomfort at the site of the blood draw, possible bruising, redness, and swelling around the site, bleeding at the site, feeling of lightheadedness when the blood is drawn, and rarely, an infection at the site of the blood draw.

_____ _____ _____

Patient Printed Name Patient Signature Date

HIPAA

It is hereby agreed that any and all information, whether written, verbal, literature, protocols or any other communications are considered proprietary and will not be used in any form or shared with any other persons or entities without the expressed written consent of Thinique Medical Weight Loss. In addition, it is agreed that all patient information is to remain confidential under the guidelines of the Health Insurance Portability Act of 1996.

_____ _____ _____

Patient Printed Name Patient Signature Date

Vitamin Consent

I_____, understand that the vitamins and supplements recommended by Thinique Medical Weight Loss are not intended as supplements for medical treatment. They are considered to be wellness products. Some supplements are contraindicated for pregnant women and therefore one should not take these products if pregnant. The FDA has not recommended any of these supplements as a treatment for a particular disease, although there is literature supporting the use of many of the types of supplement we offer. I realize that these products are sold at Thinique Medical Weight Loss as a convenience for our patients. There is no obligation that I purchase the supplements.

I have read all the above and understand all features of the above consent.

Signed:_____ Date:_____ Witness:_____

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Testosterone Supplementation Consent Form

I confirm that I have had a consultation with a Thinique Medical Weight Loss medical provider (physician, physician assistant, or nurse practitioner) whereby the risks, benefits, and possible side effects of hormone supplementation with Testosterone Cypionate have been discussed with, and understood by, me. I have experienced/am experiencing symptoms as indicated by my responses to the new patient questionnaire, as well as the following (please check all that apply):

___ Height loss, low-trauma fracture history, osteopenia, osteoporosis
___ Mild anemia (normocytic/normochromic, c/w female range)
___ Increased body fat, BMI
___ Type II Diabetes Mellitus or Metabolic Syndrome
___ My spouse/partner and I are seeking pregnancy

I understand that the purpose of testosterone supplementation is to improve my energy, exercise endurance, libido, mental focus, and overall well-being. I was given an opportunity to ask the provider questions and they were answered to my satisfaction. _____Patient Initials _____ PA/NP Initials

I am aware that it is my responsibility to have my primary care provider or urologist perform a prostate exam after 6 months of treatment and then annually thereafter. _____Patient Initials _____ PA/NP Initials

I also understand that medicine is not an exact science. Although Thinique providers will carry out my treatment carefully and per Endocrine Society Guidelines, the possibility that I may experience negative side effects is something I have considered when deciding if testosterone supplementation is right for me. I understand that possible negative side effects of testosterone treatments may include the following:

- Injection site redness, bruising, and/or discomfort
- Irritability or mood swings
- Sleep disturbances, worsening of sleep apnea
- Oily skin and/or acne
- Testicular atrophy and breast tenderness or enlargement
- Decreased sperm production
- Increased blood pressure
- Fluid retention that can cause changes in liver, kidney, and/or heart functions
- Changes in cholesterol, red blood cell, and other hormone levels
- Prostate enlargement, increase in PSA or changes in urinary stream

I understand that these possible side effects are rare and often related to over-supplementation and that the providers at Thinique Medical Weight Loss intend only to supplement my testosterone to optimal levels. Blood testing will be required in 3 to 6 month intervals to assure that appropriate dosing is achieved.

_____Patient Initials _____ PA/NP Initials

I agree that, while a patient of Thinique Medical Weight Loss, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters", pro-hormones, or any additional testosterone supplementation not provided by Thinique. I understand that additional testosterone or other steroid hormone use must be divulged to the Thinique providers. If, at any time, the use of these items is discovered, I understand that I will be discharged as a patient and will not be entitled to any refund or reimbursement of program costs. _____Patient Initials _____ PA/NP Initials

Thinique Medical Weight Loss will not be held liable for my choice to use any additional steroid hormones without their knowledge or consent.

Signed_____ Date_____

Provider_____ Date_____

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Testosterone Supplementation Consent to Treatment Form

Please read and initial beside each statement indicating that you have read, understand, and agree with:

_____ 1. This is my consent for Thinique Medical Weight Loss, including any physician, physician assistant, or nurse practitioner who works with the company, to begin testosterone supplementation therapy.

_____ 2. It has been explained to me, and I fully understand, that occasionally there are some risks and side effects associated with testosterone supplementation, including the following: Acne, breast enlargement, mood swings, fluid retention, liver or kidney stress, sleep disturbances, prostate enlargement, changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels.

_____ 3. I understand that I must have blood testing every 3 to 6 months while receiving treatment.

_____ 4. I understand that there is no guarantee as to the results of supplementation, and if I stop therapy that symptoms may return or worsen.

_____5. I understand that the medical exam performed by the Thinique provider does not take the place of a full physical exam by my personal physician.

_____ 6. I agree to have my personal physician perform a yearly full physical exam, including a digital rectal exam to screen for prostate enlargement or cancer.

_____ 7. I have had an opportunity to discuss my complete past medical and health history, including any serious problems or issues. All of my questions concerning the risk, benefits, side effects and alternatives, including not receiving treatment of any kind, have been answered to my satisfaction.

Signed_____ Date_____

Witness_____ Date_____

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NOTICE OF PRIVACY PRACTICE
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS:

We are Required By Law To:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of out notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example: we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in our medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health and Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have another relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use and disclose Health Information to contact your medical care or payment for your care, such as your family or a close friend. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS: ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissue to facilitate organ, eye or tissue donations, and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers Compensation: we may release Health Information for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks: We may disclose Health Information for public Health activities. These activities generally include disclosures to prevent or control disease, injury, or disability, report births and deaths; report child abuse or neglect, report reactions to medications or problems with products; notify people of recalls of products that they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of State, or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to See Below.

Right to Amend: If you feel that Health Information we have 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 or for our office. To request an amendment, you must make your request, in writing to See Below.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to See Below.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that we not share information about particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to See Below. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical manners in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to See Below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager. All complaints must be made in writing. You will not be penalized for filing a complaint. **OFFICE MANAGER:** Carri White info@thiniquekeller.com

Patient Printed Name	Patient Signature	Date

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