Patient Name:_____

ASPEN CLINIC WEIGHT LOSS/GAIN HISTORY

Have you tried losing weight on your own without medication? Yes / No

Please list any diets/exercise plans you have tried or trying:

_____

Are you currently getting treatment for obesity from another Physician? Yes / No

Is the Physician using medication? Yes / No List medicine:_____

Have you taken appetite suppressants before? Yes / No How long ago? _____

Was it successful? Yes / No Please list any side effects you experienced: _____

Do you exercise regularly? Yes / No How many days per week?_____

What prohibits you from exercise?_____

HIPAA PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:_____Date:_____

ASPEN CLINIC CANCELLATION AND PRESCRIPTON POLICY

The Aspen Clinic has implemented a cancellation policy. This policy enables us to better utilize available Appointments for our patients, as well as decrease the waiting time. If you are unable to keep your Appointment, we ask that you call to notify us at least 24 hours in advance, or we will charge a non- cancellation fee of $25.00 for time reserved if you do not show or call in advanced.

Please be aware that lost, misplaced, destroyed, or stolen prescriptions cannot be replaced.

I am aware of the cancellation and prescription policy.

Patient Signature:_____Date:_____