Richard Bragg, M.D.

Svelte Medical Weight Management

Dear Patient,

We would like to welcome you to our office. Our medically supervised program will provide you with the foundation to accomplish your weight loss goals quickly and safely.

Your program begins with a consultation with a member of our medical staff. During this time you will be instructed on our nutritional and exercise plan that has been selected based on your individual needs. A comprehensive blood panel, an EKG, and your weight and body fat index measurement will be performed. You will also be provided with a basic exercise regimen, which is a very important component to a successful weight loss program.

Our physician will then evaluate your medical and weight history, and make the appropriate recommendations for your individualized program. You will be prescribed and dispensed a Food and Drug Administration (FDA) approved appetite suppressant, which has been proven to be safe and effective for many years.

Our program requires weekly scheduled visits to assess your progress, dispense your medication, and make any indicated changes. We take great pride in our program, and thank you for your interest.

Kind Regards,

Dr. Bragg and Staff

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Patient Information (Please Print)

FIRST NAME	LAST NAME	DATE

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	

EMERGENCY CONTACT (Last Name, First Name)	PHONE NUMBER

Supporting you in your journey of weight loss and maintenance is very important to us. Therefore, from time to time, we may wish to send you information, samples or special offers that we may feel may be of interest to regarding Svelte Medical Weight Management and/or Zone Wellness. We may also contact you in relation to consumer research, marketing and customer surveys. If you would rather not receive additional information and/or offers, please do not check the box below.

PRIVACY: Your information will be kept strictly confidential and not provided to any third parties.

☐ **Yes, I would like to receive such information & offers by postal mail**
☐ **Yes, I would like to receive such information & offers by phone**
☐ **Yes, I would like to receive such information & offers by email**

How did you learn about the program?	
☐ Billboard	☐ Internet
☐ Magazine	☐ Newspaper
☐ Patient Referral	☐ Radio
☐ Television	☐ Other:

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Weight History

NAME	DATE

Height:	Current Weight:	What is your desired weight:
How long have you been trying to lose?		
What has been your heaviest weight?		
When were you that weight? (record your age)		
When did you first become overweight?		
What do you think is the cause of your weight problem?		
Have you ever stayed the same weight for ten (10) years or more? ☐ Yes ☐ No		
Are any members of your household overweight? ☐ Yes ☐ No If yes, please list relation and details…		

What was your motivation for weight loss before joining our program?
Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Perform better
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller sizes
- ☐ Upcoming vacation
- ☐ Look better
- ☐ Live longer
- ☐ Feel more confident socially
- ☐ Look more attractive for my partner
- ☐ Reduce medications
- ☐ Want to wear more stylish clothing
- ☐ Upcoming anniversary/birthday
- ☐ other (please describe):

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In order to assist you in achieving your weight loss goal, please check the programs that you have previously participated in. Please list under comments if you were successful in obtaining your goal, and if not why the program did not meet your expectations.

Name of Program	Results?	Why this program fell short of you expectations…
☐ Weight Watchers		
☐ Jenny Craig		
☐ Slim Fast		
☐ Atkins		
☐ South Beach		
☐ L A Weight Loss		
☐ Nutri System		
☐ Lindora		
☐ Other		

Do you exercise? If so, how often do you exercise?

☐ Never ☐ Rarely ☐ Daily ☐ 4-5 times a week ☐ 2-3 times weekly ☐ once a week

What is your exercise routine?
Check all that apply.

- ☐ Walking
- ☐ Swimming
- ☐ Dancing
- ☐ Aerobics
- ☐ Pilates
- ☐ Stairmaster
- ☐ other (please describe):
- ☐ Bicycling
- ☐ Yoga
- ☐ Sports (basketball, tennis, etc.)
- ☐ Strength training
- ☐ Elliptical
- ☐ Treadmill / Jogging

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Medical History

Family History (If blood relative has suffered the following, please indicate relationship.)			
Heart Attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

Have you ever been hospitalized? If yes, when and why?	
Year	**Illness or Operation**

Medications (Please list the medications you are currently taking, and as needed.)			
Medication	**Dosage**	**How Often**	**Reason**

Allergies (Please list any medications you are allergic to.)

Medical History (Please check YES to all that pertains to you.)								
Yes	**No**		**Yes**	**No**		**Yes**	**No**	
		Loss of hearing			Hemorrhoids			Anemia
		Ringing in ears			Hernia			Immune disorders
		Ear infections			Gall bladder			Alcohol abuse
		Bad vision			Sudden weight loss			Drug abuse
		Glaucoma			Liver disease			Hypertension
		Nose bleeds			Back pain			Heart disease
		Sinus trouble			Joint pain			Thyroid disease
		Sore throat			Broken bones			Cancer
		Allergies			Dizzy spells			Diabetes
		Hoarseness			Fainting spells			Stroke
		Pneumonia			Memory loss			Osteoporosis
		Bronchitis			Insomnia			GERD
		Asthma			Nervousness			Rashes
		Short of breath			Depression			Chicken pox
		Tuberculosis			Phobias			Mumps/measles
		Heart murmur			Manic depressive			Polio
		Palpitations			Anxiety			Are you pregnant?
		Irregular pulse			Schizophrenia			Could you be Pregnant?
		Swollen ankles			Bulimia			Other:
		Chest pain			Anorexia			
		Loss of appetite			Other eating disorders			
		Indigestion			Frequent urination			
		Stomach ulcers			Kidney disease			
		Diarrhea			Prostate disease			
		Constipation			Headaches			
		Bloody/tarry stools			Fatigue			

Appetite Suppressant and Weight Loss Consent

I hereby authorize Dr. Bragg and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise program, ZONE Wellness, and lifestyle changes. I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. Appetite suppressants labeling suggestions are based on short-term studies of 12 weeks. The experience of Bariatric physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements and injections are effective for longer than 12 weeks.

Dr. Bragg and associates believe in the off label use of medications proven to be effective in medical studies to promote weight loss and in the use of nutritional supplements and injections. These injections, nutritional supplements and medications can help you lose weight faster and make you feel better while you are losing weight. These nutritional supplements, injections and medications can boost your energy, burn fat faster, and eliminate cravings. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise or and eat fewer calories. Dr. Bragg and associates disagree with this simplistic thinking, and believes that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

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 or an exchange-eating program without the use of the appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heart beat, and heart irregularities. Less common, but more serious risks are valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that there are risks associated with obesity. Among these risks are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, hips, knees, and feet. I also understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop significant gallbladder disease during their lifetime. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible.

There is no guarantee that the program will work for me. By consenting to treatment I agree to pay in full for all visits and charges at the time of each visit. **I understand that your services are not reimbursed by insurance, and that you do not provide or fill out claim forms for insurance purposes.** I understand that no refunds are ever given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience; however, I may request that a prescription be written for the weekly dose of the medication.

By signing below I certify that I have read and fully understand this consent form. **I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction.** My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Dr. Bragg or this office's physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications.

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

I further understand that Svelte Medical Weight Management and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

My signature below indicates my consent of treatment.

Patient: ______________________ Date: ______________________

Witness: ______________________

Physician Declaration

II 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 of continuing in an overweight state. After being adequately informed, the patient had consented to therapy involving the appetite suppressants.

Physician's Signature: ______________________ Date: ______________

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Photographs Consent Form

I hereby authorize Svelte Medical Weight Management staff to take my photograph during my initial consultation, during, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and are kept in my chart at all times.

I DO _________, DO NOT _________ (Please initial one) give permission for my photographs to be used by Svelte Medical Weight Management for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

Patient: ______________________________ Date: ______________________________

Witness: ______________________________ Date: ______________________________

For office use only

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form
&
Authorization for the use of Disclosure of Individually Identifiable Health Information to Business Associates of Richard Bragg, M.D..

I, ____ , have received a copy of

Patient Name

Dr. Bragg's Svelte Medical Weight Management's Notice of Privacy Practices.

Signature of Patient	Date

I hereby authorize the use or disclosure of my individually identifiable health information as described in the referenced Notice of Privacy Practice. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations (HIPAA) or State law. This authorization expires five (5) years from the date set forth below.

Signature of Patient	Date

Patient authorization for disclosure of protected health information

I, ______________________________, D.O.B. ______________________,

SS# ____________________, authorize Dr. Bragg and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name: ______________________________

Name: ______________________________

Name: ______________________________

Name: ______________________________

______________________________ ______________________

______________________________ ______________________

Signature Date

______________________________ ______________________

______________________________ ______________________

Witness Date