Center for Wellness
WEIGHT LOSS | SKIN CARE | INTEGRATIVE MEDICINE

MORRISTOWN
1843 West Morris Blvd
(423) 581-7976

SEVIERVILLE
1360 Dolly Parton Pky
(865) 429-0921

ROGERSVILLE
1101 E. McKinney Ave
(423) 272-1900

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WEIGHT LOSS PROGRAM INFORMATION

We want you to know…The calorie deficit and portion-controlled diets are used with patients who are overweight. These methods of weight reduction have been described and evaluated in many professional medical journals since 1974.

Your role…Your success depends upon your commitment to fulfilling your obligations during treatment. You should be willing to:

- Provide honest and complete answers to questions about your health, medications, weight, eating, and lifestyle patterns.
- Devote the time needed to complete and comply with the course of treatment as prescribed.
- Attend your appointments regularly and follow your diet and exercise prescription.
- Obtain blood/diagnostic tests which your provider may deem necessary during your treatment.
- Advise the clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important. This affords the best chance of intervening before a problem becomes serious.

Risks Associated with Being Overweight…People who are overfat, overweight or obese have greater tendencies toward:

- High blood pressure, Diabetes/Metabolic Syndrome, Hyperinsulinemia, High Cholesterol, Asthma, Esophageal Reflux, Fatigue, Heart Attack, Stroke, Peripheral Vascular Disease, Abnormal Cardiac Rhythms, Pulmonary Hypertension, Decreased sense of smell, Obstructive Sleep Apnea, Arthritis, Subfertility/Infertility, Polycystic Ovarian Syndrome and various types of cancer.

These risks/conditions can be reduced or eliminated with weight loss (starting around 5-10 percent of initial weight).

Medications…If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your weight changes.

Unknown Side Effects...The possibility always exists in medicine that the combination of any disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary.

Common Side Effects…During a low calorie diet, common side effects can be: *a reduced metabolic rate, increased urination, dizziness, sensitivity to cold, a slower heart rate, dry skin, fatigue, diarrhea, constipation, bad breath, dry or brittle hair, hair loss, muscle cramps, or menstrual changes.* These responses are temporary and resolve when calories are increased after the period of weight loss. A drug monograph with more specific information for each medication is available on our website and by request.

Reduced Potassium Levels…It is important to consume a nutritionally balanced diet. Failure to do so may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities.

Gallstones…Overweight people develop gallstones at a rate higher than normal weight individuals. It is possible to have gallstones and not know it. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight, especially rapidly, may increase the chance of developing stones or sludge and increase the size of existing stones within the gallbladder. Should symptoms develop (commonly fever, nausea and a cramping right upper abdominal pain) or if you know or suspect that you already have gallstones, let your provider know immediately. Gallbladder problems may need medication or surgery to remove the gallbladder, and less commonly, may be associated with more serious complications or even death.

Pancreatitis, or an inflammation/infection of the pancreas, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications or even death.

Pregnancy...If you become pregnant, report this to your health care professional and physician immediately. Your calorie restricted diet and anorectic medications must be stopped promptly to avoid further weight loss and potential damage to a developing fetus. ***You must take precautions to avoid becoming pregnant during the course of weight loss.***

The risk of weight regain….Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular exercise, adherence to a healthy diet, and having a coping strategy for weight regain before it occurs. Successful treatment may take months or years.

Sudden Death…Patients with morbid obesity and serious health problems such as severe hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without these problems. **Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established.** Other rare risks are primary pulmonary hypertension and valvular heart disease.

Your Rights and Responsibility…You may leave treatment at any time. You have a responsibility to notify the provider that you are discontinuing treatment and to find another provider who is able to assume medical care for you after you leave treatment.

No Guarantees…I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

Food Items…Food items purchased in the office are non-returnable once purchased.

Supplements…Dietary supplements may be added to your program and may include vitamins, minerals, and/or lipotropics (fat burners) given in oral or injection form. A drug monograph is available on our website and by request for each supplement added to your program. The scientific literature supporting the provider's use of these supplements may be limited; however, the potential benefit of use of such supplements for most individuals is felt to outweigh the risks.

FDA Labeling…Appetite suppressants have labeling which recommends to use the medications for obese individuals, for time periods up to 12 weeks, and at the dosage indicated in the labeling.

OMA Guidelines for Anorectic Usage: We adhere to the guidelines for anorectic usage as recommended by the Obesity Medicine Association. Indications for initiation of anorectics include:

- ☐ BMI > 30 in normal healthy individuals
- ☐ BMI > 27 in individuals with co-morbidities (DM, HTN, Insulin/Leptin resistance, vascular disease, hyperlipidemia, asthma, cancer, GERD, OSA, kidney disease, osteoarthritis, gall stones, PCOS, psoriasis, acrocordon, acanthosis nigricans, or other related conditions)
- ☐ Current weight > 120% of a long standing healthy weight maintained after the age of 18.
- ☐ Body fat >30% in females and >25% in males (Sarcopenic Obesity)
- ☐ Waist-hip ratio > 0.8 in women or > 0.95 in men
- ☐ Waist circumference > 35" in women and > 40" in men
- ☐ Any co-morbid condition that is aggravated by weight
- ☐ Prevention of weight regain in a person who has previously lost weight
- ☐ Weight loss for occupational needs
- ☐ Prevention of weight gain in a person who has a familial/genetic predisposition to obesity, cancer, or other obesity related conditions.

Long Term Use…Additionally, an anorectic medication may be used for individuals that have shown previous benefit and not had adverse reactions (beneficial risk-to-benefit ratio) for the purpose of restarting a weight loss program, to lose weight that has been recently gained following a therapeutic loss of weight, or to maintain weight loss on a chronic basis even if the above criteria are no longer met.

Off Label Prescribing… A provider is not required to use the medication as the labeling suggests. This is called off label prescribing and is specifically provided for by the FDA. We have found appetite suppressants and other non-anorectic type medications to be helpful for periods exceeding 12 weeks and at doses larger than those suggested in the labeling. The indications for these usages are based on our experience, the experience of our colleagues, and guidelines from the OMA. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects. We believe the probability of such side effects is outweighed by the benefit of the appetite suppressant for the given dose and indication. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the medication(s) may give.

Dispensing and Furnishing…In general, weight loss related medication(s) will be prescribed and dispensed within this office. At your request, you will be given an opportunity to count your pills to ensure accuracy at the time of dispensing. Dispensed prescriptions may not be refunded or exchanged after leaving the office. You may request to have the prescription filled at any pharmacy of your choice at any time, but there will still be charges for the office visit and any other service(s) rendered.

Responsibility…It is my responsibility to follow dosing instructions carefully and to report promptly any medical problem(s) that may be related to my weight control program. In general, medications will not be prescribed without an office visit. One time, short term exceptions can be decided on a case by case basis. We reserve the right to refuse such an exception to anyone. Abuse of this policy can result in dismissal from the clinic. I must be re-evaluated by the provider within 30 days of starting any new medication. ***If I am prescribed a controlled medication from this clinic, I agree to only obtain that medication from providers of this clinic.*** Obtaining controlled medications from multiple providers is illegal and will be reported to law enforcement as required. Diversion of medications to other individuals is grounds for dismissal. Random urine drug testing may be done and if refused, is grounds for dismissal.

Refunds…I understand that no refunds will be given after services are performed.

Purpose…I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. My continuing to receive weight loss treatment will be dependent on my progress in weight reduction and weight maintenance.

Drug Testing…If you are drug tested as part of your employment or for another purpose, you may test positive for amphetamines or their derivatives while taking certain weight loss medications such as phentermine. If needed, you may be given a doctor's note to state you are taking a medication to aid in weight loss.

Alternatives…I understand there are multiple ways to decrease my body weight and to maintain a healthy weight. In particular, a reduced calorie diet or protein sparing modified fast and regular exercise without the use of appetite suppressants or other medications or supplements could help if followed, even though I may be hungrier, fatigued, or the weight loss may not be as great without these adjunctives.

Risk of Proposed Treatment...The use of weight loss related medications, involves some risk. Risks are higher still for dosages that exceed the recommended labeling. Common side effects of stimulant type appetite suppressants include: **insomnia, palpitations, dry mouth, headaches, psychological problems, medication allergies, short term high blood pressure, and dependence** (exceedingly rare). Blood pressure can become more elevated when taken with pseudoephedrine, an over the counter cold medicine. Rare, but serious risks include **primary pulmonary hypertension and valvular heart disease.** These side effects were observed rarely with Fenfluramine and have a very rare occurrence with other appetite suppressants and have not been found to have a direct association. These risks could be slightly higher with Belviq (Lorcaserin), a weight loss medication that is mechanistically similar to Fenfluramine. Medications containing naltrexone will cause opiates to be less effective. Medications containing topiramate (Qsymia) have been found to have an increased rate of cleft palate formation in a developing fetus. Monthly pregnancy tests may be required. Women of childbearing age need to take care not to become pregnant while taking medications to aid in weight loss. These and other possible risks could, on rare occasion, be serious or fatal.

Date: _____

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Name:	Date of Birth:
Street: Primary Phone:	Occupation:
City: State: Zip Code:	Email:
Alternate Phone: Contact me by: ☐ Text ☐ Cell ☐ Email	Marital Status:
Hobbies/Interests:	Emergency Contact Name:
How did you hear about us?	Emergency Contact Phone:

General Health:

Primary Care Physician:

Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1 Average hours of sleep nightly?

Do you feel content in life? ☐ Yes ☐ No At work? ☐ Yes ☐ No With family? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, what type and how often?

Do you wear contact lenses? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No How many cigarettes per day? How many years?

Do you drink alcohol? ☐ Yes ☐ No Type: ☐ Beer ☐ Liquor ☐ Wine Drinks per day: Drinks per week:

Do you have any metal implants, a pacemaker, or body piercings?

Do you pass out or get dizzy / lightheaded with needles (labs, shots, etc)? ☐ Yes ☐ No

Please list any previous surgeries:

Medications: Please list all prescription and OTC medications and supplements you use. Include those you use on an as needed basis if they are used at least weekly. This includes vitamins, herbs, nasal sprays, and inhalers.

Medication Name	Dose	How Often	Purpose	How Long Used?

Allergies: Please list any food, medication, or environmental allergies and your reactions.

Illnesses/Chronic Conditions: Please mark all that apply.

☐ Vision problems	☐ Tuberculosis	☐ Anemia	☐ Hepatitis	☐ Fibromyalgia
☐ Glaucoma	☐ High Blood Pressure	☐ Easy bleeding / bruising	☐ Stomach Ulcers	☐ Chronic Pain Syndrome
☐ Cataracts	☐ High Cholesterol	☐ Blood clots	☐ Colitis / Diverticulitis	☐ Multiple Sclerosis
☐ Hearing problems	☐ Heart Failure	☐ Autoimmune Disease	☐ Irritable Bowel Syndrome	☐ Headaches
☐ Ear Infections	☐ Heart Attack	☐ Diabetes	☐ Bladder / Kidney Infections	☐ Seizures
☐ Asthma	☐ Heart Murmur	☐ Thyroid Disease	☐ Kidney Stones	☐ Neuropathy
☐ Allergies	☐ Heart Valve Disease	☐ Genetic Disorders	☐ Urinary problems	☐ Depression / Anxiety
☐ Sinus problems	☐ Irregular Heartbeat	☐ Acid Reflux	☐ Urinary Incontinence	☐ Bipolar Disorder
☐ Bronchitis	☐ Stroke	☐ Pancreatitis	☐ Jaw Pain / TMJ	☐ Drug Abuse / Alcoholism
☐ COPD / Emphysema	☐ Varicose Veins	☐ Gallbladder Disease / Stones	☐ Arthritis	☐ Eating Disorder
☐ Pneumonia	☐ Rheumatic Fever	☐ Liver Disease	☐ Bulging / Degenerative Disks	☐ Herpes / Shingles / Cold Sores
☐ Cancer (Type: _____)		☐ Other: _____		

Family Medical History:

Do any of the following conditions run in your family? Please mark all that apply and indicate who has the condition.

☐ High blood pressure _____	☐ Diabetes _____	☐ Lung disease _____
☐ High cholesterol _____	☐ Obesity _____	☐ Liver disease _____
☐ Heart disease _____	☐ Thyroid disease _____	☐ Stomach disease _____
☐ Heart attack _____	☐ Arthritis _____	☐ Genetic diseases _____
☐ Stroke _____	☐ Cancer _____	☐ Other: _____

Diet & Nutrition:

Highest adult weight: Age:	Lowest adult weight: Age:	Avg. adult weight:
How many oz. of water do you drink daily?	How many soft drinks do you drink daily?	Other caffeine?
How many times per week do you eat out?		
Have you tried multiple diets in past? ☐ Yes ☐ No		
Are you currently on a special diet? ☐ Yes ☐ No If yes, what type?		

Diet & Nutrition (continued):

Have you tried any of the following diet programs in the past? (Mark all that apply.)

□ Low fat	□ Zone	□ Ornish	□ Medifast / Optifast
□ Atkins	□ Paleo	□ DASH	□ Weight Watchers
□ South Beach	□ Keto / ketogenic	□ Mediterranean	□ Other: _____

Please list what and what time you typically eat for each of the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Skin Care:

Are you under the care of a dermatologist? □ Yes □ No

Do you use: □ Acutane □ Retin A □ Renova □ Adapalene □ Other prescription skin products

Have you had: □ Botox □ Dermal fillers □ Chemical Peels □ Microdermabrasion □ Other treatments_____

Are you currently using any products that contain: □ Glycolic Acid □ Lactic Acid □ Hydroxy Acid □ Vitamin A

Do you have any skin sensitivities or irritants: □ Yes □ No Reaction: _____

Skin Maintenance:

Products You Use: □ Cleanser □ Toner □ Moisturizer □ Exfoliator □ Masque

Skin Type: □ Oily/Congested □ Dry/Dehydrated □ Sensitive/Redness □ Acne □ Sunburned

How often do you go tanning or are exposed to the sun? □ Daily □ Weekly □ Monthly □ Rarely

What are your skin care goals?

For Women Only:

Are you currently sexually active? □ Yes □ No		Sexual Orientation:	
Are you currently pregnant or nursing? □ Yes □ No			
Number of pregnancies:	Number of children born:	# Vaginal Deliveries:	# C-Sections:
Last menstrual cycle:	Avg cycle length:	Age of onset:	
Current method of birth control:		Last pelvic exam:	Last mammogram:
Have you had a hysterectomy?	Do you still have ovaries?		Age of menopause:

For Women Only (continued):

Do you suffer from any of the following female related symptoms / conditions?

□ Irregular periods	□ Cravings	□ PCOS / Ovarian cysts
□ Heavy periods	□ Irritability	□ Yeast infections
□ Spotting	□ Fatigue	□ Bacterial vaginosis
□ Cramps	□ Breast tenderness	□ Hot flashes
□ Fluid retention	□ Infertility	□ Mood swings
□ Low sex drive	□ Endometriosis	□ STDs

For Men Only:

Are you currently sexually active? □ Yes □ No Sexual Orientation:

Do you suffer from any of the following male related symptoms / conditions?

□ Impotence	□ Weak erection	□ Premature ejaculation
□ Low sex drive	□ Increased sex drive	□ Prostate Problems
□ Testicle Pain/Lump	□ Penis discharge	□ Infertility
□ Moods Swings	□ Fatigue	□ STDs

Please note any other information you feel is relevant to your health history that has not been mentioned elsewhere:

OFFICE USE ONLY: HISTORY REVIEW/UPDATE ***Please have patient review history, mark NC if no changes, initial and date. Patient to complete a new history if any changes have occurred since the last history review was completed.***

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General Consent to Treat and Acknowledgement of Office Policies

- It is my choice to receive services from Center for Wellness. I have completed this form to the best of my knowledge.
- I have stated all medical conditions that I am aware of and have listed all medications that I am taking. I am aware that this office monitors the Tennessee Controlled Substance Monitoring Database, and the discovery of any controlled medications prescribed to me that have not been disclosed to staff will be construed as an act of deception violating the trust inherent in a provider/patient relationship which may result in this office declining to participate in my care.
- I will update the staff at Center for Wellness of any changes to my contact information or health status.
- I consent for the CFW providers and staff to perform reasonable and necessary medical examination, testing and treatment for the condition(s) which have brought me to seek care at this office, both at this initial visit and any future visit(s). I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
- I acknowledge that I may leave treatment at any time and that it is my responsibility to notify the provider(s) that I am discontinuing treatment. If I leave treatment, I will find another provider who is able to assume care for me.
- I understand that if a prescription is felt to be appropriate, it will be dispensed at this office, if available, unless I request otherwise.
- I have been given the opportunity to review the HIPAA/Notice of Privacy Practices and understand that a copy is available to me at any time at my request.
- I understand that Center for Wellness does not participate with any insurance provider(s) and that payment in full is expected at the time of service.
- I understand that all sales are final. No refunds or exchanges are given on any products or services.
- If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to notify staff and reschedule my appointment. I understand I may be charged a fee for failing to keep or cancel an appointment under these guidelines and this fee may be required to be paid prior to any future services being rendered. I understand a non-refundable deposit may be required for some skin care services.
- I grant permission to the designated person(s) named below to: make or confirm appointments; have access to test findings; have access to telephone communications and answering machine messages, as well as other common means of communication; pick up medications and/or supplements; be made aware of my diagnosis, prognosis, treatment plans; and have access to my financial health information. Unless otherwise noted below, this authorization grants CFW permission to leave messages on my answering machine/voicemail using my protected health information regarding information deemed appropriate/necessary by my health care provider(s). I understand that this authorization is voluntary. I understand that once this information is released, it may no longer be protected by federal privacy regulations.

By assigning a designated party, Center for Wellness will be allowed to give information to the following individuals:

Name: _____ Relationship to patient: _____

Phone Number: (_____) _____ Cell Number: (_____) _____

☐ Full Access ☐ Rx/Product Pick Up Only ☐ Other: _____

Name: _____ Relationship to patient: _____

Phone Number: (_____) _____ Cell Number: (_____) _____

☐ Full Access ☐ Rx/Product Pick Up Only ☐ Other: _____

☐ **PLEASE DO NOT LEAVE MESSAGES ON ANSWERING MACHINE**

_____ _____

Patient Signature Date

Consent to Photograph

I, *(print name)*_____,

a current patient/client of Center for Wellness ("CFW"), hereby authorize CFW, by and through its employees, agents or contractors, to photograph me and/or any portion of my body, in order to provide supporting documentation of my medical condition and care provided.

The term "photograph," as used in this agreement, shall mean motion picture or still photography in any format such as slides, negatives, and/or prints, as well as videotape, video disc, and any other means of recording and reproducing images.

Such photographs and/or videos shall be used only for medical records, teaching, publication, marketing, or scientific research by my provider and Center for Wellness, provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my provider to protect my confidentiality or emphasize a treatment area.

I understand that my physician, other providers of my health care, insurance company or third party payor may be furnished with a copy of said photograph, if needed to document the care provided by CFW.

I understand that I have the right to revoke this Consent provided that I do so *in* ***writing,*** except to the extent that CFW has already used or disclosed the information in reliance on this Consent. This Consent will remain in effect until modified or revoked by the patient/client.

☐ By checking this box, I decline to authorize CFW the use of my photograph(s) for teaching, publications, research, or marketing purposes in print, electronic, or other media formats.

Patient Name *(print)* _____

Patient Signature _____ Date_____