KINGWOOD WELLNESS CLINIC®
REGISTRATION FORM

(Please Print Clearly)

Today's date:			PCP:			
PATIENT INFORMATION We verify your identity with your Drivers License						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		DL #	Cell:			
P.O. box: EMAIL:	City:	State:	ZIP Code:			
Occupation:	Employer:	Pharmacy:				
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr. ❑ Business Card	❑ Billboard	❑ Google		
❑ Family	❑ Friend	❑ Newspaper	❑ Internet Search	Billboard location:		
Other family members seen here:						

Advance Beneficiary Notice of Non-coverage

I hereby certify that the above information is true and correct to the best of my knowledge. I hereby authorize Kingwood Wellness clinic to release any of my patient information required for continued care to other Providers that I may utilize for my care. I understand and agree, that I am financially responsible for any balance owed for my care This is a fee for service clinic. Payment due on day of service. _____**Initial**

We will not authorize lab slips or lab testing and that the lab testing must be done outside of any insurance plan Dealing with insurance companies and HRT has been difficult and insurmountable. We, therefore, wish to advise you that your HRT treatment will not involve any use of insurance or completing insurance forms or statement of medical necessity." _____ Initial**

Your telephone number is collected to send appointment reminders as well as clinic specials. You may "opt out" of receiving texts at any time. Please sign below to indicate that you understand and consent to treatment and agree to receive our text reminders._____**Initial**

We strive to achieve optimal health & wellness through nutrition, exercise, hormone balance and optimization. Our programs, protocols and philosophy are designed to maximize your QUALITY of life. If your hormone levels are in a "normal" range but are low and you have symptoms we may start therapy to alleviate symptoms. ._____**Initial**

Patient signature (SIGN HERE) *Date*

REASON FOR VISIT TODAY

Please check the reason you are coming in today; if it is not listed please write in the reason, if doing lab-work what is the reason:

_____
_____
_____
_____

- □ New weight patient
- □ New Hormone
- □ B-complex Injection
- □ Thyroid Evaluation
- □ Botox Injections
- □ Laser Evaluation
- □ Juverderm/Fillers
- □ Fatigue

- □ Hormone Imbalance
- □ Loss of sexual desire
- □ Low Testosterone Symptoms

(Patient MUST read and sign in order to be seen)

KINGWOOD WELLNESS CLINIC®

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Current or referring doctor:		**Date of last physical exam:**	
PERSONAL HEALTH HISTORY			
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	

List or circle any medical problems that other doctors have diagnosed

☐ Low thyroid ☐ high thyroid	☐ Cancer	☐Elevated PSA
☐ High blood pressure	☐ Depression	☐ Constipation
☐ High Cholesterol	☐ Bipolar	☐ Snoring or sleep apnea
☐ Diabetes (insulin or no-insulin)	☐ Reflux	☐ Waking at night to urinate

Surgeries ☐ **No Surgeries Please list or circle if listed**

Year	Surgery	
	☐ C-section How many?_____	Thyroidectomy ☐R ☐Left ☐Total
	☐ Hysterectomy ☐ Tubal Ligation	Gastric ☐ Staple or ☐ Banding
	☐ Gallbladder removed (cholecystectomy)	Heart Surgery
	☐ Appendectomy	Other:
	☐ Tonsillectomy	Other:
	ANYTHING ELSE:	Other:

Other hospitalizations

Year	Reason	Age if you do not remember year

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins ,inhalers and including birth control

Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No Known Drug Allergies**

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

PLEASE ANSWER ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting ?			☐ Yes	☐ No
	Have you taken appetite suppressants in the past?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ☐ Beer ☐ Wine ☐ Liquor ☐Tequila ☐Vodka				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	

	☐ # of years	☐ Or year quit ☐ Do you desire to quit?_____		
Sex	Are you sexually active?		☐ Yes	☐ No
	If yes, are you trying for a pregnancy?		☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?		☐ Yes	☐ No
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you get dizzy on standing?		☐ Yes	☐ No
Quality of Life	HOW WOULD YOU RATE YOUR HEALTH AND WELL-BEING			
	Poor **Fair** **Good** **Very Good** **Excellent**			
	** This helps us evaluate our treatments, please compare o the best you ever felt health-wise			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father (F)			**Children** (M)male (F)female	☐ M ☐ F	
Mother (M)				☐ M ☐ F	
Diabetes	☐ M ☐ F			☐ M ☐ F	
Heart Disease	☐ M ☐ F			☐ M ☐ F	
Hypertension	☐ M ☐ F		**Grandmother** *Maternal*		
Thyroid	☐ M ☐ F		**Grandfather** *Maternal*		
Kidney	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have problems with weight gain or losing weight?	☐ Yes	☐ No
Do you occasionally feel depressed or have depressed moods?	☐ Yes	☐ No
Is your concentration decreased?	☐ Yes	☐ No
Do you have problems with occasional constipation?	☐ Yes	☐ No
How often are bowel movements?		
Do you get cold easily or have cold hands or feet?	☐ Yes	☐ No
Have you noticed excessive hair loss?	☐ Yes	☐ No
Is your skin dry?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Poor energy or fatigue?	☐ Yes	☐ No
Bone / Joint Pain	☐ Yes	☐ No

WOMEN ONLY		
DO NOT WRITE N/A, EVERYTHING IS APPLICABLE		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days Length of periods_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Miscarriage_____Abortions_____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Date of last pap and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)		

Date of last mammogram?_____Results: ☐ Normal ☐ Abnormal (Please list any findings)

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)	☐ Yes	☐ No

OTHER PROBLEMS		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Hormonal symptoms

I hereby certify that the above information is true and correct to the best of my knowledge._____

Notice of Privacy Practices Acknowledgment

KINGWOOD WELLNESS

2316 TIMBER SHADOWS DRIVE, #100
KINGWOOD, TX 77339
PHONE: 281-852-1800

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (**"HIPPA"**), I have certain rights 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 have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to so as documented below:

Date: Initials: Reason:

KINGWOOD WELLNESS CLINIC®

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESANTS

I. Procedure and Alternatives:

1. I, _____ authorize Associates to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indication on the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

   Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated on the labeling.

   As a bariatric physician/provider, **I have found the appetite suppressants to be helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling.** As a physician/provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent long-term studies and the recommendations of university-based investigators. Based on these I have chosen, when indicated, to use appetite suppressants for longer periods of time, and at times in increased doses.

   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 (as noted below).

   As a bariatric clinician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant when used for longer periods of time and when indicated in increased doses. 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 that the appetite suppressants may provide.

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight and any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. 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. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other methods 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 program or an exchange eating program without the use of appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: **nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities.** Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. **Risks Associated with Being Overweight or Obese:**

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, diabetes, heart attacks, heart disease, and arthritis of the joints, hips, knees and feet. I understand these risks may be most if I am not very much overweight, but that these risks can go up significantly the more overweight I am.

IV. **No Guarantees:**

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

V. **Patient's Consent:**

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____

PATIENT: _____

VI. **Clinician Declaration:**

I 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 that 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 has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature/Nurse Practitioner

Kingwood Wellness

1543 Green Oak Place, Suite 200

Kingwood, Texas 77339

(281)852-1800

Informed Consent for Off-Label Medication

The off-label use of a medication is defined as the use of a medication that is currently approved for use by the FDA in a manner that is different than its approved use. An example of this would be quinine, a medication to treat malaria, for leg cramps. This is a very effective medication for this condition and is safe. Although the FDA has not approved this use, it is very common for doctors to prescribe this medication for this reason. Many medications are commonly used off-label. Sometimes, the off-label use of a medication will lead to further studies being done and for the FDA additional indications and uses for the medication. An example of this is topamax, a medication that was originally approved to treat seizures. It was later used to treat bipolar disorder. It wasn't a very effective medication for these conditions. It was commonly used off-label to treat migraines. It now has FDA approval for this and is also approved for weight loss. Off-label use of medication is a common, almost daily practice for physicians. Prescribing medications in forms other than what was FDA approved such as a tablet versus a capsule, cream, troche is considered off-label. Slow releasing phentermine to control hunger longer is another example of off-label use.

The American Medical Association and the Texas Medical Board have put forth guidelines for the off-label use of medications. It is the policy of this clinic to follow those guidelines.

Because off-label use of medication usually begins with individual ideas or experiences of individual physicians/providers, often there are other physicians who are not familiar with certain off-label uses of medications. This can be confusing to the patient and can affect treatment with these medications. You are being prescribed medication for off-label use. In addition to this general information on off-label prescribing, you will receive specific instructions about the medication you will be receiving. You may talk with other physicians about this medication before beginning treatment. If you receive any conflicting information about this treatment, you are free to discontinue the treatment or have further discussions about it. We would also be willing to provide your other physicians with additional information regarding your treatment if needed.

Name_____ Date_____

I have received and understand the above information. I consent to off-label treatment.

Signature_____

PATIENTS BEHAVIOR TOWARDS STAFF MEMBERS

Dear Patient,

Your treatment at Kingwood Wellness is founded on our set of core values and principles which we hold paramount. Our staff works diligently to maintain and adhere closely to these values throughout your health journey with us.

OUR CORE VALUES AND PRINCIPLES

-We love our patients and building trusting relationships

-We are humble, life-long learners pursing optimal wellness.

-We prioritize productivity and work-life balance and boundaries.

-We provide personalized, hands-on care for patients.

-We empower our patients and cultivate an authentic community.

In our best effort to uphold these values as top priority, our staff have been throughly trained to provide our patients with the utmost care and respect.

Likewise, we expect patients behave appropriately and respectfully towards our staff. Verbal disrespect, abuse, or mistreatment of any kind will not be tolerated.

A patient's first offense will result in a warning letter, stating the incident and requesting appropriate and respectful behavior going forward. The second offense will result in complete dismissal from our practice. However, the severity of the first offense may require immediate dismissal from the practice. Examples of offenses that may result in immediate termination include but are not limited to name-calling, yelling/screaming, swearing/cursing, or threatening.

Please contact our office if you have any concern about the behavior of a staff member, and we will connect you to the appropriate supervisor related to your concern.

We are so grateful to be a part of your healthcare team and look forward to working with you on your wellness journey.

Kindest regards,

The Team at Kingwood Wellness

Signature _____ **Date** _____