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MED SPA

Kristin Tarbet, MD, Mike Symond, MD & Gay Sleight, PA-C

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: (_____) _____Cell: (_____) _____

Age: _____Date of Birth: _____

Email: _____

Gender: Male Female Marital Status: M S W D

Social Security Number: _____

Employer: _____

Employer Address: _____

Employer Phone: (_____) _____

Nearest Relative: _____

Address: _____

Phone #: (_____) _____ Relation: _____

Responsible Party or Spouse

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: (_____) _____

Date of Birth: _____ SS#: _____

Employer: _____

Employer Address: _____

Employer Phone: (_____) _____

Credit Policy & Financial Agreement

Each patient, not the insurance company, is responsible for payment for all charges to his/her account at the time services are rendered unless special arrangements are made in advance.

I authorize insurance benefits to be paid directly to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I also authorize the physician to release any information acquired in the course of my evaluation or treatment to the insurance company.

Payments on accounts billed are expected within 30 days.

Delinquent accounts will be charged interest at 1½% per month. I agree to pay collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

I/We agree to pay all attorney's fees, court costs, filling fee (including charges of commissions), that may be assessed by any collection agency retained to pursue this matter. I/We further understand that this may be as much as 50% of the principal owing. I/We further agree to pay interest at the rate of 1 ½% per month (18% per year).

ATTENTION: IMPORTANT INSURANCE INFORMATION

Since it is vital that our patients understand our relationship with insurance companies this statement is necessarily straightforward to prevent any possible misunderstandings, disagreements or disappointments.

If you believe that your medical needs are covered by insurance, please be aware that the health insurance contract you have is between you and your insurance company, not Amara and your company. We work with your insurance company on all claims, however the insurance company does have a final say as to what is and is not covered. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full.

LAB INSURANCE MAY NOT COVER ALL FEES

If you have insurance, all labs costs are submitted to your insurance company by the Laboratory, not by Amara. We can't guarantee the payment to the lab company by your insurance, as the contract you have is between you and your insurance company.

Patient Initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, private insurance and other health plans to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information and records necessary to secure the payment. To the extent necessary to determine liability for payment, and obtain reimbursement, I authorize disclosure of portions of my medical records. A photocopy of the assignment is considered as valid as original.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party Date

_____ _____

Witness Date

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Name: _____ DOB: _____ Date: _____

Present/Previous Occupation: _____ Marital Status: S M D W

Past Medical History

- ☐ High blood pressure
- ☐ Hear attack
- ☐ Heart failure
- ☐ Heart valve problems
- ☐ Liver disease/Hepatitis
- ☐ Anemia
- ☐ Depression
- ☐ Mental illness
- ☐ Stroke/Mini stroke
- ☐ Brain Tumor
- ☐ Cancer: _____
- ☐ Diabetes: Type I or Type 2
- ☐ Gout
- ☐ Epilepsy/Seizures
- ☐ Abnormal Clotting
- ☐ Permanent Make up: _____
- ☐ Over-active thyroid
- ☐ Under-active thyroid
- ☐ Asthma
- ☐ Lung problems
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Other: _____

Women: # of pregnancies: _____ # of live births: _____

Have you had any surgeries?

Type of Surgery	Hospital	Year

Please list your medications, include herbs/vitamins.

Medication	Dose	Medication	Dose

Family Medical History

Have any of your blood relatives had any of the diseases listed above?

Relative:	Living?	Deceased?	List Diseases:	Cause of Death
Father				
Mother				
Sister/s				
Brother/s				
Grandparents				

Personal & Social History

List members in household

Name:	Birthday

Do you have smoke detectors in home? Y / N
Do you use a seatbelt? Y / N
Do you exercise? Y / N How often? _____
Do you use Alcohol? Y / N How often? _____
Did you ever use alcohol? Y / N How long? _____
Do you smoke cigarettes/chew tobacco? Y / N How often?___ X ____
Do you ever use illegal drugs? Y / N
If yes, what kind? _____
Did you ever use illegal drugs? Y / N
If yes, what kind? _____

Immunizations:

Did you complete your childhood series? Y / N
Last Tetanus booster? _____ Last Hep B series? _____
Last Pneumonia shot? _____ Last Flu shot? _____
Last TB skin test? _____ Other: _____

Have you ever had any of following procedures? What year?

Chest X-ray:_____ ECG:_____ Holter:_____ Stress test:_____
Echocardiogram:_____ Angiogram:_____ PFT's:_____ Overnight oximetry:_____
Sleep study:_____ PSA:_____ Pap smear:_____ Mammogram:_____

Do you have any allergies to medications? Y/N If yes, please list what kind of reaction?

_____

Are you seeing any specialists? Y/N If yes, please list:

_____

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HCG DIET INFORMED CONSENT

HCG is a prescription medication used by Amara Med Spa in its weight loss program.

With any drug there is the possibility of an allergic reaction or unusual reaction that may cause skin rash, difficulty breathing, collapse, or even death.

HCG is virtually free of negative side effects, but because you must follow a very low calorie, low fat diet that can sometimes trigger a gallbladder attack in individuals who are genetically pre-disposed to gallbladder disease or my increase symptoms of gout. Your medication will be discontinued if there is a severe adverse reaction.

I, _____ understand that the program and medications may involve risk. I understand that there are no refunds, returns or store credit for medication and that there is no weight loss guarantee with our program. Although HCG has been used for weight loss since the 1950's, I understand that HCG is not FDA approved for weight loss. I have read and understand the information given to me about the medications. I have asked and had answered any questions that I may have after reading this form. I understand the possible side-effects and agree to advise Amara Med Spa should they occur. I understand that I may quit the program at any time. I agree to stop the HCG if I become pregnant and agree to advise Amara Med Spa should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact Amara Med Spa. If I experience an emergency situation, I understand that I need to go to an emergency facility.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED AND AGREE TO NOTIFY AMARA MED SPA OF ANY CHANGE IN YOUR HEATLH STATUS.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

558 E. Riverside Dr. Suite 200 St. George, UT 84790
(435) 652-9355 Fax: 652-5358

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CONSENT FOR APPETITE SUPPRESSANT

Diethylproprion/Tenuate: 25 mg (tablet) and 75 mg ER (tablet)

- **Indications:** Indicated for patients greater than 16 years of age for the short-term adjunct in a regimen of weight reduction based on exercise, diet and behavioral modification in the management of obesity for patients with the initial body mass of ≥30 kg/m2, or ≥27 kg/m2. This FDA approved appetite suppressant stimulates the satiety center in the hypothalamus, which is similar to amphetamine.
- **Contraindications:** Hypersensitivity to drug/ class/ components: MAO inhibitor use within 14 days (hypertensive crisis); Glaucoma; Agitates states; Pulmonary Hypertension; Drug abuse history; Pregnancy; Breastfeeding; Anorexients/Stimulants.
- **Cautions:** Avoid abrupt withdrawal; Caution in mild hypertension; Caution in Epilepsy; Certain OCT cold and cough medications; May impair ability to drive or operate heavy machinery.
- **Adverse Reactions:** Abuse, dependency; Withdrawal if abrupt discontinuation with high doses and /or long-term use; Psychosis; Tachycardia; Hypertension; Palpitations; Restlessness; Insomnia; long-term use; Euphoria; Tremor; Headache; Dry mouth; Constipation; Diarrhea; Abdominal Pain; Urticaria; Impotence; Libido changes; Leukopenia; Agranulocytosis; Bone marrow depression; Pulmonary hypertension and cardiac valvular disease has been reported in patients who had taken a combination of Phentermine with fenfluramine or dexfenfluramine.

Phentermine/Adipex-P: 15 mg (capsule), 30 mg (capsule) and 37.5 mg (capsule and tablet)

- **Indications:** (Same as Diethylproprion) Indicated for patients greater than 16 years of age for the short-term adjunct in a regimen of weight reduction based on exercise, diet and behavioral modification in the management of obesity for patients with the initial body mass of ≥30 kg/m2, or ≥27 kg/m2. This FDA approved appetite suppressant stimulates the satiety center in the hypothalamus, which simulates amphetamine.
- **Contraindications:** Hypersensitivity to drug/ class/ components; MAO inhibitor use within 14 days (hypertensive crisis); Advanced Arteriosclerosis; Cardiovascular Disease; Moderate to Severe Hypertension; Hyperthyroidism; Glaucoma; Agitated States; Drug abuse history; Pregnancy; Breastfeeding; Anoreiants/Stimulants.
- **Cautions:** Avoid abrupt withdrawal; Caution in mild hypertension; Caution if Diabetes Mellitus; Certain OCT cold and cough medications.
- **Adverse Reactions:** Abuse, dependency; Withdrawal if abrupt discontinuation with high doses and /or long-term use; Psychosis; Tachycardia; Hypertension; Palpitations; Restlessness; Insomnia; long-term use; Euphoria; Tremor; Headache; Dry mouth; Constipation; Diarrhea; Abdominal Pain; Urticaria; Impotence; Libido changes; Leukopenia; Agranulocytosis; Bone marrow depression; Pulmonary hypertension and cardiac valvular disease has been reported in patients who had taken a combination of Phentermine with fenfluramine or dexfenfluramine.

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PhenMax/Phentermine Topamax compound

- **Indications:** (Same as Diethylproprion) Indicated for patients greater than 16 years of age for the short-term adjunct in a regimen of weight reduction based on exercise, diet and behavioral modification in the management of obesity for patients with the initial body mass of ≥30 kg/m2, or ≥27 kg/m2. This FDA approved appetite suppressant stimulates the satiety center in the hypothalamus, which simulates amphetamine.
- **Contraindications:** Hypersensitivity to drug/ class/ components; MAO inhibitor use within 14 days (hypertensive crisis); Advanced Arteriosclerosis; Cardiovascular Disease; Moderate to Severe Hypertension; Hyperthyroidism; Glaucoma; Agitated States; Drug abuse history; Birth Control; Pregnancy; Breastfeeding; Anoreiants/Stimulants.
- **Cautions:** Avoid abrupt withdrawal; Caution in mild hypertension; Caution if Diabetes Mellitus; Certain OCT cold and cough medications.
- **Adverse Reactions:** Abuse, dependency; Withdrawal if abrupt discontinuation with high doses and /or long-term use; Dizzyness; Tingling or Numbness; Fatigue; Taste Change; Psychosis; Tachycardia; Hypertension; Palpitations; Restlessness; Insomnia; long-term use; Euphoria; Tremor; Headache; Dry mouth; Constipation; Diarrhea; Increased Perspiration; Abdominal Pain; Urticaria; Impotence; Libido changes; Leukopenia; Agranulocytosis; Bone marrow depression; Pulmonary hypertension and cardiac valvular disease has been reported in patients who had taken a combination of Phentermine with fenfluramine or dexfenfluramine.

I have read and understand the indications, contraindications and adverse reactions which may occur as a result of using the above named drugs.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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Name:_____ Date:_____

WEIGHT HISTORY QUESTIONAIRE			
Height		**Blood Pressure**	
Current Weight		**Goal Weight**	

1. What is your maximum weight? _____ How long ago? _____
2. What type of diet programs have you been on? _____

   _____
3. If you took phen/phen how long did you take it? _____
4. Did you have any cardiac problems/lung problems after phen/phen? _____
5. Do you have a family history of obesity/diabetes/cancer? _____
6. Do you have regular bowel movements? _____
7. When you exercise, do you normally sweat? _____
8. Have you ever had an eating disorder such as bulimia or anorexia? _____
9. What do you think your weight should be? _____
10. Where do you usually gain weight? _____
11. Have you been tested for insulin resistance? _____
12. Are you a compulsive over-eater? _____
13. Do you eat from boredom? _____
14. How many times per week do you exercise? _____
15. Do you have a thyroid disorder or other endocrine abnormality? _____
16. Do you eat regularly? _____
17. How much water do you usually drink? _____
18. Do you have constant rashes or chaffing because of excessive fat tissue? _____
19. Do you have or have you ever abused laxatives? _____
20. Do you snack between meals? _____
21. Do you suffer from (circle all symptoms) headaches, swollen ankles, rheumatic pains, and breathlessness?__
22. Do you have stretch marks on your body? _____ If yes, where? _____
23. Have you ever been told you are insulin resistant? _____
24. Have you ever had elevated blood glucose? _____
25. How many hours do you sleep at night? _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement Form

I am aware of, have received or been offered a copy of Amara's Notice of Privacy Practices and I have been given the opportunity to review it.

Date: _____

Birth date: _____

Patient Printed Name: _____

Patient Signature: _____

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