AT THE CROSSROADS
WEIGHT MANAGEMENT
Medication, Food Management, Exercise & Counseling

NEW PATIENT APPLICATION

Patients Name (Printed): _____

Address: _____ City: _____ State/Zip: _____

Home Number: _____ Cell Number: _____ DOB: _____

Email: _____ Occupation (Optional): _____

Referred by: _____

Emergency contact name: _____ Phone number: _____ Relationship: _____

☐ Please check if you do not wish to be contacted via phone or be left a voice mail.

Personal Health History

Do you or did you previously have a history of any of the following?

Heart Problem/ Chest Pains	YES/ NO	Sleeping Problems	YES/ NO	Thyroid Problems	YES/ NO
		Chronic Fatigue	YES/ NO	Are you pregnant or breast feeding?	YES/ NO
High Blood Pressure	YES/ NO			Have you ever had a stroke, heart attack, or	
		Arthritis	YES/ NO	CVA?	YES/ NO
Low Blood Pressure	YES/ NO				
		Headaches	YES/ NO	Have you ever had or been diagnosed with	YES/ NO
Respiratory Problems	YES/ NO			Glaucoma?	
		Leg Cramps	YES/ NO		
Diabetes Type 1	YES/ NO			Any other health problems, sicknesses, diseases,	YES/ NO
		Swelling of Hands or Feet	YES/ NO	blood disorders or recent hospitalization within	
Diabetes Type 2	YES/ NO			the last year?	
		Abdominal/ Bowel Disorders	YES/ NO		
High Cholesterol	YES/ NO			History of drug or alcohol abuse?	YES/ NO
		Indigestion	YES/ NO		
Cancer	YES/ NO			Any drug allergies? If yes, please describe	YES/ NO
		Irregular Menstruation	YES/ NO	below.	
Female Organ Problem	YES/ NO				
		Controlled Substance Use	YES/ NO		
Kidney Issues or Disease	YES/ NO				
		Recreational Drug Use	YES/ NO		
Epilepsy or Seizures	YES/ NO				
		Alcohol Use	YES/ NO		
Anxiety/ Depression	YES/ NO				
		Tobacco Use	YES/ NO		
Dizziness	YES/ NO	Packs per day if yes:			

List of Allergies:

_____

_____

List of Medication(s):

_____

_____

☐ Please check if you are *NOT* currently on any medication

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Uncontrolled blood pressure and/ or heart problems must be cleared in writing by current attending physician/ primary care provider prior to the dispense of any controlled appetite suppressants.

Family Health History

Does anyone in your family have a history of any of the following?

Diabetes	YES	NO	High blood pressure	YES	NO	Female organ problems	YES	NO
Cancer	YES	NO	Low blood pressure	YES	NO	Kidney trouble or disease	YES	NO

If you answered yes to any of the above, please describe: _____

Nutritional History

How would you rate your overall health? _____Excellent _____Good _____Fair _____Poor

Have you ever been on a supervised weight loss program before? Yes No

If Yes, explain: _____

What is your weight loss goal? (please list any or all the following) __Lbs._____Size_____Inches

What have you done in the past to achieve these goals?_____

How much time can you devote to exercising: each day? _____ each week?_____

How frequently do you eat: meals per day? _____ snacks per day? _____

How many times a week do you eat out?_____

What is your fluid intake PER DAY? List number of glasses/cups in each category.

WATER_____ COFFEE_____ SODA _____ TEA _____ ENERGY DRINKS_____ ALCOHOL_____

What are the dietary supplement currently being taken if any?

Please finish this statement: The best way to describe my nutritional habits is

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Do you have any of the following? (Check any that apply)

Sweet Cravings——— Alcohol Cravings——— Cheese Cravings——— Night Hunger——— Bread Cravings———

Salt Cravings——— Soda Cravings——— Other: ———————————————————————————

What are your specific weaknesses when trying to lose weight?———————————————————————

_____

How did you hear about *At the Crossroads Weight Management*?

Internet——— Craigslist——— Money Mailer——— Friend/Family——— Savvy Shopper———

Living Social——— AZ Notas——— Radio——— Weekly Plus——— Other———

PATIENT CONSENT:

Patient Consent: The above information is a true representation of my current health status. I have read and understand the above and do hereby agree to treatment administered to me, including medications for weight control. I, the undersigned, having been informed by *At the Crossroads Weight Management*, PLLC of the hazards and possible consequences involved in treatment by medications, supplements, injections for the purpose of weight loss, nevertheless consent to such treatment and agree to hold *At the Crossroads Weight Management*, PLLC. free and harmless for any claims, demands, or suits for damages from any injury or complications whatever, save negligence, that may result from such treatment.

Notice: All patients may receive medications dispensed by *At the Crossroads Weight Management*.

Pregnant or nursing mothers should not be taking this medication. If you suspect you are pregnant, discontinue medication and notify us *At the Crossroads Weight Management.*

Signed: Date:

IF PATIENT IS UNDER THE AGE OF 18, A PARENT OR LEGAL GUARDIAN MUST SIGN ABOVE

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Treatment Consent Form

I authorize *At The Crossroads Weight Management*, PLLC and all designated assistants, to help me in my weight reduction efforts.
I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications.

I have read and understand my doctor's statements that follow:
Medications, including the appetite suppressants, have labeling worked out between the manufacturers of the medications and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are based upon short-term studies (up to 12 weeks) using the dosages indicated in the labeling.

Other treatment options may include a low-calorie diet, or a protein supplemented diet (food management). I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack, stroke and heart disease, joint damage of the hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 to me and my questions have been answered to my complete satisfaction. I have been given all the time I need to read and understand this form.

If you have any questions regarding 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.

Patient:_____ Date:_____ Clinical Associate:_____
(Or person with authority to consent for patient)

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of *At The Crossroads Weight Management's* Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended notice of the Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail sent to:

Print Name: _____ DOB: _____ Telephone: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:

____ Patient or guardian of minor patient

____ Guardian or conservator of an incompetent patient

____ Beneficiary or personal representative of deceased patient

_____
Patient's Name

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Financial Policy

Thank you for selecting *At The Crossroads Weight Management*, PLLC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Master Card, American Express, and cash. ALL SERVICES ARE NON-REFUNDABLE.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all the above and have agreed to these statements.

Signature: _____ Date: _____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties of this contract, by entering it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician. The amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously an Arizona superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator.

Patient shall pursue his/her claims with reasonable diligence. and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision (s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Physician's or Authorized Representative Date	Patient Signature Date
Print Name of Physician or Medical Group	Print Patient Name
Signature of Translator (if applicable)	Patient Representative Signature (if applicable)
Print Name and Relationship to Patient	Print name of Translator (if applicable)