S.I. Medical Inc.

Patient Basic Information (to be filled out by patient)

Your name: Last_____ First_____ MI____ Age_____

Name you prefer to be called:_____

Your address: _____ Apt/Suite#_____

City_____ State_____ Zip Code_____

Home PH(_____)_____ Cell PH(_____)_____

Work PH (_____)_____Place of Employment _____

Birthdate_____/_____/_____Sex: M / F. Has your gender been change due to a Medical/ Surgical procedure Y____N____

If the answer to the above is yes, pls. list date of procedure and Hormonal therapy_____

_____.

Health Insurance? Y /N Name of Carrier_____

Email Address_____@_____

Please leave messages/ appt. reminders :(please check all that apply)____Home PH ____Cell PH ____Work PH ____ Email

____May use clinic name in message ____**DO NOT use clinic name in message**

How did you hear about us? (Please check all that apply)

___Radio Ad – Station?_____ ___Mailer ___Internet ___Saw the Sign ___TV – Station?_____

Newspaper – Which?_____ ____ Word of Mouth / Friend_____

____ Referred by a Doctor/Practioner: Name_____

Allergy Information

Are you allergic to **SULFA**- type medications? **Yes** / No

Please list any other medications that you are allergic to: _____

Emergency Contact

(Person to contact incase of an emergency)

Name_____ Relationship_____ PH_____

Medical Info

Your Primary Care Physician/Provider:_____

Physician's/Provider's Clinic Name_____ PH_____

City_____ State_____ FAX_____

Patient Name _____

INITIAL VISIT PROGRESS NOTE- NEW PATIENT

1) Chief complaint: ***(reason for visit):***	___excess weight gain ___excess fatigue/low energy ___weight-related health problems (ie: Diabetes, High Cholesterol, High Blood Press.) ___excess hunger/cravings (sweet, salty, etc) _____ exercise intolerance ____ Dyspnea upon exertion. ___other?_____
2) HPI:	***Weight gain history:*** **Age of onset:**___childhood___teen___adult___post-pregnancy___post-menopause Length in month/years_____
Rate:	___rapid gain ___slow gain
Probable Causes:	___less active ___stress ___medications___increased appetite/hunger ___illness/injury ___psych/physical/sexual abuse: Please Explain _____
Methods Tried:	***Weight Loss History:*** **Diets?:** ___***Weight Watchers*** ___***NutraSystem/JennyCraig*** __***SouthBeach*** ___***Atkins*** ___***CabbageSoup*** ____***Other:***_____
	Non-Prescription Meds?: ___**Alli** ___**HCG** ___**Hydroxycut** ___**Hoodia** ___**Dexatrim** **Other:** _____
	Prescription Meds?:____Phentermine ___Fen/Phen ___Meridia
	Weight-Loss surgery?:___*Lap Band* ___*Gastric Bypass*___*Other*_____
What worked?:	**Diets?:** ___***Weight Watchers*** ___***NutraSystem/JennyCraig*** __***SouthBeach*** ___***Atkins*** ___***CabbageSoup*** ***How long was weight loss maintained (in months)*** _____
What failed & why?	

Patient Name _____

What time of day are you usually most hungry?	____morning___mid-day___evening___nighttime
Triggers:	***What often triggers you to eat?:***___certain people ___certain places ___certain activities ___certain feelings___stress___sadness/depression ___anxiety ___boredom___anger
Eating problems:	***Have you ever suffered from:***___anorexia___bulimia___binge eating ___night eating(getting up in the middle of the night to eat) ***Have you ever sought/received treatment for an eating disorder? Y / N*** Explain:_____
Questions:	**1)*Do you ever eat a large amount of food in a short time without really being hungry?*** Y / N ***2) Do you feel guilty or ashamed when you do this?***Y / N
Meal Types:	***Do you usually/often:***___eat out ___drink coffee or tea :# of cups per day ____ Do you use sugar_____ artificial sweetners_____ artificial creamer _____ ___eat at home(home cooking) ___ drink soda:# per/day_____: DIET or REG
Tempting foods:	___sweets___salty___fried___starches/carbs ___Everything !
Favorite foods: (can't live without)	
Foods you can't/won't eat:	
Exercise history:	**Current Exercise Routine :**(what activity? How often? How long?)
Previous types of beneficial/enjoyable activities:	___walk___jog___bike___swim___dance___skate _____class ___ gym workout/weights ___sports_____
Do you have any physical condition(s) that limit your activity?	Explain:_____ _____

Do you have any home exercise equipment?	___treadmill ___eliptical___stationary bike____regular bike ___home gym ___weights ___exercise videos ___bands ___balance balls___fitness video games (Wii, Xbox, etc.) ___other:_____

Patient Name _____

3) Past Medical History: *Check all that apply to you:*

___Diabetes

___Gestational Diabetes

___High Blood Pressure

___Hypothyroidism (low)

___Heart Murmur

___Atherosclerosis

___Angina/Chest Pain

___Heart Attack

___Abnormal Heart Rhythm

___Congestive Heart Failure

___Heart Valve Disease

___Shortness of Breath

___Cancer_____

___Hyperthyroidism (high)

___Liver Disease _____

___Kidney Disease _____

____Polycystic Ovarian Syndrome (PCOS)

___TIA (mini-stroke)

___Stroke

___High Cholesterol/ Triglycerides

___Glaucoma

___Have your eyes examined at least once per year?

___Edema/Water Retention

___Anemia

____Adrenal Disease: (ie:Cushing's disease, etc.)

____Stomach Problems/Heartburn/Reflux

____Alcoholism

____Asthma

___Blood Clots _____lungs (PE) _____legs (DVT)_____arms (DVT)

___Emphysema/COPD

____arthritis

___Pulmonary Hypertension

___Hepatitis B Date Tested _____

___Do you have to use oxygen

___AIDS/HIV Date Tested _____

___Sleep Apnea

___Do you use CPAP

___Other: _____

Medications / Dosage:	*Medication allergies / reactions:*
	SULFA? Y / N
	Other Med Allergies? Y / N (If Yes, Please List)

Patient Name _____

Please list all Supplements & Vitamins used	*Please list all OTC medications used*

4) Past Surgical History:	
___tonsillectomy	___joint replacement _____
___appendectomy	___joint surgery _____
___laparoscopic gallbladder removal	___cardiac stents # _____
___open gallbladder removal	___heart bypass (CABG)
___tubal ligation	___heart valve replacement
___vasectomy	___hernia repair _____
___hysterectomy ___Partial? ___Total?	___bunionectomy ___Left ___Right
___C-section #_____	___carpal tunnel release ___Left ___Right
___D&C # _____	___eye surgery ___Cataract Removal ___Lasik
___weight loss surgery (lap band, gastric bypass)	___Other :

5) Social History:	
Psychological History:	
___depression	___anxiety
___bipolar disorder	___schizophrenia
___post-traumatic stress syndrome	___other psychological disorder
History of: ___physical abuse ____emotional abuse ___sexual abuse	

Patient Name _____

History of drug use: now or previously?		
Drugs used:	***Currently ? (x)***	***Previously ? (x)***
____Marijuana		
____Heroin		
____Ecstasy		
____Speed / Methamphetamine		
____Cocaine /Crack		
____Prescription drugs_____		
____Other _____		

Women only: ***Current age:_____***	Number of pregnancies?
Age started menstruating/periods?	Number of live births?
Do / Did you have regular periods? **Y / N**	Able to get pregnant? **Y / N** If no, why not?
Do / Did you have menstrual problems? **Y / N** If yes, what kind?_____	Currently Pregnant? **Y / N** Currently trying to get pregnant? **Y / N**
Age of menopause? (if applicable)	Currently sexually active? **Y / N**
	Currently using birth control? **Y / N** What kind?_____
	Currently breast feeding? **Y / N**

Family Setting :

___Single ___ Married ___ Live with significant other ___ Divorced ___ Remarried ___ Widowed

Children?# of sons_____ # of daughters_____ # of grandchildren_____

Employed? Y / N **Full-Time____ Part-Time____** **What is your job?** _____

What shift do you work?_____ **Do you rotate shifts?** _____

Patient Name _____

Tobacco Use?

Currently **:Smoke ?** Y / N If Yes : ___Cigarettes : # packs / day? ____ **Chew?** Y / N If Yes : # cans / day____

___Cigars : # / day? ____ ___Pipe : # bowls / day? ___

Age when started ? ____ ***Previously*** : Smoked ? Y / N # of years ? ____Quit? Y / N ____ years / months ago

Alcohol Use?

How often do you drink? Monthly or less ___ 2-4 times a month ___2-3 times a Week ___4 or more times a Week ___

On a typical day when you do drink, how many drinks containing alcohol do you have? _____

Sleep Pattern:

Sleep Well? Y / N If No, why ?___Trouble falling asleep? ___Trouble staying asleep?

# of total hours of sleep / night (average) _____

Feel rested upon waking? Y / N Get sleepy/tired during waking hours? Y / N

Motivation for weight loss:

Are you ***CONFIDENT*** you can lose weight this time?

1	2	3	4	5	6	7	8	9	10
NO		A LITTLE		SOME		VERY		ABSOLUTELY	

How ***IMPORTANT*** is it to you that you lose weight?

1	2	3	4	5	6	7	8	9	10
NOT		SORT OF		SOMEWHAT			VERY		EXTREMLY

6) Family History: _____ Adopted? Y / N

Father: living? **Y / N** Age:_____ deceased? **Y / N** at what age?_____ ___ Unknown

Mother: living? **Y / N** Age:_____ deceased? **Y / N** at what age?_____ ___ Unknown

Patient Name _____

Diseases : (family history)	What family members?
Obesity	
Diabetes (childhood onset)	
Diabetes (adult onset)	
High blood pressure	
Heart or vascular disease	
Heart Attack	
Stroke	
Thyroid disease	
High cholesterol/triglycerides	
Cancer_____	
Other_____	

Patient's (or Guardian's) Signature _____ **Date** _____

Patient Name _____

SI Medical

SI Medical, Inc. 1909 W. Coolidge Ave Marion, IL 62959 (618)997-5677 Fax- (618)997-3627
SI Medical, Inc. 123 Lincoln Place Court Belleville, IL 62221 (618)234-5677 Fax- (618)234-5679

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Patient Address:** _____

Date of Birth: _____ **Social Security Number:** _____

I hereby authorize **SI Medical, Inc.** to receive protected health information from; and/or release protected health information to: (Complete name of entity releasing/receiving information)

_____

_____

Information to be disclosed:

Medical Records/Recent Office Notes History and Physical Discharge Summary
Laboratory Results Medication(s)/Allergy List EKG Other: _____

Purpose of Release:

Transfer/Change of Care Continue/Referral Care Legal/Insurance/ WC Other: _____

NOTE: The following protected health information; ___HIV/AIDS, ___Mental Health Records, ___Substance Abuse, ___ Communicable Disease, ___Genetic Information **WILL NOT** be released unless specified and signed by patient below. (Release of Mental Health Records may require the consent of the treating provider or a court order.)

Patient Signature: _____

The authorization shall be in force for (1) year/ 365 days after the date signed at which time the authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to SI Medical, Inc., 1909 W. Coolidge Ave., Marion, IL 62959. I understand that the revocation is not effective to the extent that Si Medical, Inc. has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure (*except those noted above) by the recipient may no longer be protected by federal law. SI Medical, Inc. will not condition my treatment or payment for treatment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this authorization. The information authorized for release may include records that are protected under Federal confidentiality rules. The Federal rules prohibit anyone receiving this information from making further release unless expressly permitted by the written authorization of the person to whom it pertains or otherwise permitted. I understand that I may, review and request copies of the information received from the use of this authorization. SI Medical, Inc. may charge a fee for copies requested.

_____ _____

Signature of Patient /Authorized Representative **Date**

_____ _____

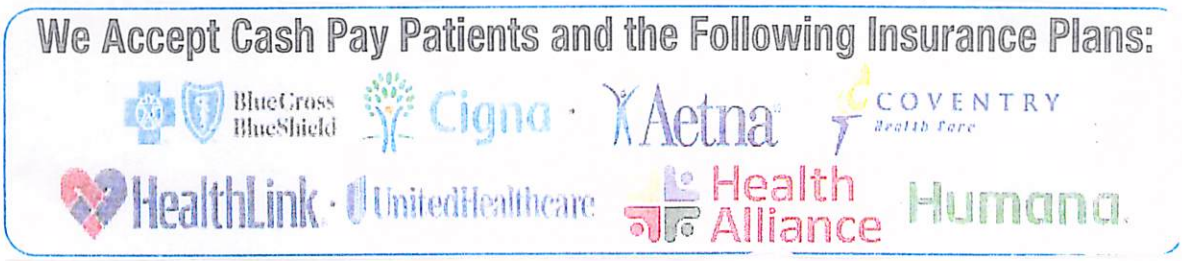
SI Medical Staff Witness **Date**

SJ Medical, Inc.

Payment Policy

Thank you for choosing us as one of your health care providers. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We currently participate in the following insurance plans:



We do not accept Medicare or Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If your **Primary Insurance** is a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

SJ Medical, Inc.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. Missed appointments. Our policy is to charge $25 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Charges will apply after the 2nd missed appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

SI MEDICAL INC.

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESANTS

1. I, _____ (patient or patient's guardian) authorize **Dr. Donald Griffin,** and associates, and SI Medical Inc. to assist me in my weight reduction efforts. Any successful weight loss program requires that I be fully committed to making the appropriate lifestyle changes. I understand my treatment may involve, but not be limited to, the use of appetite suppressants possibly for a longer duration, and possibly, in higher doses, than what is indicated in the medication package insert/labeling. I understand that my program must also consist of a medically supervised balanced deficit diet and regular exercise program, (as instructed). It may also include instructions in behavior modification techniques, and possibly other vitamins and supplements.

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

   "Medications, including the appetite suppressants, have a package insert/labeling worked out between the makers of the medication and the Food and Drug Administration (FDA). This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions ae generally based on shorter term studies (up to 12 weeks) using the dosage indicated in the package insert/labeling."
   "As a licensed physician, I have found the appetite suppressants helpful for periods in excess of the studied duration, and at times in larger doses than those suggested in the labeling. As a physician, I am **not** required to use the medication only as the labeling suggests, but I do use the labeling as one source of information, along with my own experience, the experience of my colleagues, recent, longer term studies, and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, to increase doses."
   "However, it is possible, as with most other medications, that there could possibly be serious side effects with these medications (as noted below). "
   "As a licensed physician, I believe the possibility/probability of such side effects is outweighed by the benefit of the appetite suppressant use, possibly for longer periods of time and/or in increased doses, in some cases, due to the significant risks associated with remaining Overweight/Obese (as noted below). However, you must decide if you are willing to accept the risks of side effects, even if they may be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully, and to report to the doctor/practioner treating me for my weight loss/management, 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 in my desire to decrease my body weight/fat, and to be able to maintain this weight loss. I understand my continuing to receive weight loss treatment, and possibly, medications, will be dependent on the medical judgment of my doctor/practitioner, my other health issues and on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight/fat and to be able to maintain this weight loss. I agree that I am enrolling in this program voluntarily, and I understand that I may stop it at any time.

RISKS OF PROPOSED TREATMENT:

I understand this authorization is given with the knowledge that the use of appetite suppressants for, in some cases, longer duration and in higher doses, than indicated in the labeling, involves some risks and hazards. The more common include: medication allergies, dry mouth, constipation, dehydration, shakiness/tremors, nervousness, sleeplessness/insomnia, headaches, anxiousness, mood changes, weakness, tiredness, elevated eye pressure (glaucoma), elevated blood pressure, rapid heartbeat, palpitations, 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. As always, if I am experiencing a medical emergency, I will seek emergency treatment immediately.

RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE:

I am aware that there are certain risks associated with remaining overweight /obese and I am willing to change my practices and habits to improve my health and well-being. Among them are tendencies toward painful arthritis/degeneration of the spine and joints: hips, knees and feet, high cholesterol/triglycerides, high blood pressure, diabetes, obstructive sleep apnea and other respiratory problems, infertility, sexual dysfunction, atherosclerosis, heart disease, heart attack, stroke, kidney and/or liver disease, certain types of cancer and sudden death. I understand these risks can go up significantly the more overweight/obese I am.

PROGRAM RESTRICTIONS:

The programs offered by Dr. Donald griffin, his associates, and SI Medical Inc., offer protocols that require continued medical supervision. As the patient, I am responsible for reading the materials, following the program as directed, and keeping my appointments. I understand that my continuing to receive weight loss treatment, and possibly, medication, will be dependent on the medical judgment of my doctor/practitioner, my other health issues and on my progress in weight reduction and weight maintenance, **I agree that I will take my medication ONLY as directed, and NEVER share my medication with friends or family, as this could be grounds for immediate dismissal as a patient of Dr. Donald Griffin and associates, and SI Medical Inc.**

I agree that I will not combine these medications with any other appetite suppressants, prescription or nonprescription stimulants, herbal remedies, or any other medications or supplements, without first consulting my practitioner regarding possible interactions. I have provided a thorough medical history and have reported all medications that I am taking. I will notify Dr. Donald Griffin, and associates, and SI Medical Inc., if my medication regimen should change I will notify Dr. Donald griffin, and associates, and SI Medical Inc. of any of my upcoming events (i.e. surgeries, vacations, cessation of programs, etc.) so that they may plan my treatment accordingly. I will immediately notify them if I should find out that I am pregnant or if I plan on becoming pregnant.

NO GUARANTEE:

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

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/PRACTITIONER NOW BEFORE SIGNING THE CONSENT SIGNATURE FORM.

PHYSICIAN'S DECLARATION:

I have explained the contents of this document to the patient and have answered all the patients related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with a diet and exercise regimen, the benefits and risks of the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight / obese state. After being adequately informed, the patient has consented to weight loss/weight management treatment indicated above.

Physician's/Practitioner's Signature

Patient's (or Guardian's) Signature

WOMEN ONLY

Special Consent to treatment:

I understand that appetite suppressant/anorectic medications should not be taken during pregnancy, due to the possible chance of damage to the fetus. The medications have been explained to me fully and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will immediately stop taking any of these medications, and notify this clinic / doctor / practitioner, *and* my OB / GYN practitioner immediately.

I also understand tht appetite suppressant / anorectic medications should not be used while breast feeding. I am not currently breast feeding, and I agree not to do so while taking any of these medications.

Patient's (or Guardian's) Signature:_____ Date:_____

Provider's Signature: _____ Date:_____

Patient Consent:

- **I have read and understand the above agreement. I'm ready to get started!**
- I have been given all the time I need to read and understand this form.
- I have read and fully understand this consent form.
- I have been allowed and encouraged to ask any questions regarding the risks/hazards of the proposed weight loss treatment, and/or other possible alternative treatment options.
- My questions have been answered to my complete satisfaction.
- I hereby agree to, and give my consent for the proposed weight loss/weight management treatment prescribed/provided by Dr. Griffin, and associates, and SI Medical Inc.

Patient (or Guardian) Signature _____ Date/Time _____

Witness' Signature _____Date/Time _____

Financial Policy

By agreeing to treatment, I agree to pay in full for all services and medications at the time services are rendered. I understand that I can pay with Visa, Mastercard, check and/or cash. I understand that I may choose to bill my medical insurance for services provided to me, if Dr. Donald Griffin, and associates, and SI Medical Inc. are preferred providers of such insurance. I also understand that I may be responsible for any co -pay, deductible or co-insurance that I may owe, either the day of service or after my claim has processed with my insurance. I also understand that my plan may not cover such services in which I would then be responsible. I understand that if Dr. Griffin, and associates and SI Medical Inc. are not a preferred provider to my insurance company, they do not provide, or fill out claim forms for insurance purposes. Dr. Donald Griffin, and associates, and SI Medical Inc. agree to provide me with information needed so that I may complete my insurance reimbursement claim forms, to the best of their ability, but can make no guarantee as to payment of these claims. I may contact my benefit administrator to see if the services are covered under a Health Spending or Flexible Spending account.

I understand that any written materials, except business cards and advertisement brochures, provided to me by Dr. Donald Griffin, and associates, and SI Medical Inc., are for my own personal and private use. These materials are the exclusive property of Dr. Griffin, and associates, and SI Medical Inc., I agree that I will not duplicate, sell or in any way transfer them to any other person without explicit written permission from the above named property owner(s).

Please sign below to indicate that you have read and understand the above and agree to our terms.

Patient (or Guardian) Signature_____ Date _____

HIPPA Privacy Notice

I have received a copy of the HIPPA privacy notice. YES / NO

Patient (or Guardian) Signature:_____ Date _____