TRIMBODYM.D.™
WEIGHT LOSS / ANTI-AGING

Patient Information Sheet

*Please fill out this form in print and answer as many questions as possible. Items in **BOLD** are **REQUIRED.***

Legal Last Name:	**First Name:**	**MI:**
Marital Status (Circle One): Single Married _____	**Sex** (Circle One): Male	Female
Date of Birth: / /	**Social Security Number:** -	-
Street Address:		**Apt.#:**
City:	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Employer:	**Your Email:**	
How were you referred to our program? (Circle One): Groupon Living Social Yelp Internet LVAC		
Family/Friend Referring Friend/Relative's Name:		**Other:**

If the Patient is Under 18 years of age, please answer the following questions:

Guardians Name:	Guardian's SS#:
Guardian's DOB: / /	Guardian's Home Address:

Emergency Contact

Name:	**Relationship:**	**Phone:**

The above information is true to the best of my knowledge.

I understand the weight loss and anti-aging programs provided by TrimBodyMD are generally considered an elective program. TrimBodyMD are not credentialed with any insurance company and are "CASH PAY ONLY PROGRAMS", which is not usually covered by an insurance policy. TrimBodyMD is an elective program that does NOT bill insurance carriers. Payment for services rendered are Due at the Time Services are Rendered.

Printed Name: _____ Signature: _____ Date Signed: _____

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Patient Name: _____ Date: _____

PRESENT MEDICAL HISTORY

Are you under a doctor's care at the present time? Yes / No
If yes, for what: _____

Are you currently in a pain management program or on disability? Yes / No

Do you have a family/primary care physician (PCP) in the Las Vegas area? Yes / No
If yes, physician name: _____

Are you taking any prescribed medications at the present time? Yes/No

Med: _____ Dosage: _____ Med: _____ Dosage: _____

Med: _____ Dosage: _____ Med: _____ Dosage: _____

Are you pregnant? (Females Only) Yes / No

Are you currently on hormone replacement therapy (HRT)? Yes / No
(Includes Birth Control)

Estrogen: _____ Progesterone: _____ Testosterone: _____
Growth Hormone: _____ BCP: _____ Other: _____

Are you currently taking any vitamin or health supplements? Yes / No
_____Multivitamin _____L-Carnitine _____CLA _____Anti-oxidants
_____Protein bars/shakes Other: _____

Do you have any allergies or adverse reactions to medications or substances (such as latex)? Yes / No

Med: _____ Reaction: _____

Med: _____ Reaction: _____

Do you Smoke? _____ Yes *(Currently)* _____ No *(But I have in the past)* _____ No ***(Never)***

Do you drink alcohol? Yes/No
How often & how much: _____
1-7 drink/week *More than 7 drinks/week*

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Patient Name: _____ Date: _____

PAST MEDICAL HISTORY

Please circle all that apply

ALLERGIES: *food sensitivities, bee stings, seasonal rhinitis:*

CARDIAC ISSUES: *chest pain, hypertension, heart attack (MI), irregular heartbeat (arrhythmia), palpitations, bypass surgery, pace maker, other:*

CIRCULATION ISSUES: *blood clots, DVTs, poor leg circulation, feet swelling, other:*

DIABETES-RELATED ISSUES: *eye problems, kidney problems, neuropathy, other:*

DIGESTIVE ISSUES: *nausea, reflux (GERD), constipation, bloating, diarrhea, peptic ulcers, gluten sensitivity (sprue) gall bladder problems, other:*

EYE ISSUES: *glaucoma, cataracts, other:*

JOINT ISSUES: *osteoarthritis, rheumatoid arthritis, fibromyalgia, osteoporosis, other:*

KIDNEY ISSUES: *kidney stones, urination problems, prostate problems, other:*

LUNG ISSUES: *asthma, COPD, sleep apnea, other:*

NEUROLOGICAL ISSUES: *migraines, stroke, other:*

PSYCHOLOGICAL ISSUES: *anxiety, depression, anorexia, bulimia, alcohol abuse, drug abuse, diagnosed mental illness, other:*

SURGERY: Specify_____ Date: _____
Specify_____ Date: _____

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Patient Name: _____ Date: _____

DESCRIBE YOUR TYPICAL ENERGY LEVEL OVER THE PAST FEW MONTHS:
(check the statement that best applies)

☐ I do other activities when not at work but I am usually too tired to exercise

☐ I am not usually fatigued and I exercise 1-3 times per week

☐ I exercise 4 or more times per week

How many hours of television do you watch each day? _____

Have you ever considered bariatric surgery? Yes/No
(stomach stapling, gastric bypass, gastric band)

How often do you eat out? _____

How much do you spend a week on food? _____

PLEASE LIST YOUR DAILY FOOD INTAKE:
(PLEASE BE AS SPECIFIC AS POSSIBLE, INCLUDING # OF SODAS, ETC.)

Breakfast: _____

Mid-morning snack: _____

Lunch: _____

Mid-afternoon snack: _____

Dinner: _____

Late Night snack: _____

OTHER HEALTH & WELLNESS CONCERNS

Please check any concerns, procedures or products that may be of interest to you (check all that apply):

☐ Botox
☐ Excessive Sweating
☐ Dermal Fillers (Juvederm, Restalyne)
☐ Acne/Acne Scarring
☐ Cellulite Reduction/Removal
☐ Skin Care Advice/Products
☐ Skin Tightening

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Patient Name: _____ Date: _____

Has any blood relative ever been diagnosed with any of the following medical conditions?

Diabetes	Yes / No	Who: _____
Glaucoma	Yes / No	Who: _____
Heart Disease/Stroke	Yes / No	Who: _____
High Blood Pressure	Yes / No	Who: _____
Kidney Disease	Yes / No	Who: _____
Obesity	Yes / No	Who: _____
Psychiatric Disorder	Yes / No	Who: _____
Thyroid Problems	Yes / No	Who: _____

DIET HISTORY

What is the primary reason for your decision to lose weight?
☐ Want to look better ☐ Concerned for my health ☐ Need to for my job/special event

When did your weight problem start?
☐ Childhood After pregnancy ☐ After menopause ☐ Came on gradually

Have you ever used any of the following weight loss methods?

Prescription Diet Pills Yes/No List: _____

Natural Supplements Yes/No List: _____

Food Plans Yes/No List: _____

Foods/Drinks dislikes: _____

Foods/Drinks you crave: _____

What time of day or night are you the hungriest? _____

Do you tend to eat more due to stress or when experiencing an emotional upset? Yes/No

9310 Eastern Ave. Suite 122 Las Vegas, NV 89123 ▪ 10300 W Charleston Blvd #21, Las Vegas, NV 89135
(702) 489-3300 *office* www.TrimBodyMD.com (702) 410-9143 *facsimile*

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WEIGHT LOSS / ANTI-AGING

Low Testosterone Questionnaire
ADAM Questionnaire (Androgen Deficiency in the Aging Male)

Answer YES or NO to each of the following questions:

		YES	NO
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and /or endurance?		
4.	Have you recently noticed a decreased ability to focus/or concentrate?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

9310 S. Eastern Ave. #122 Las Vegas NV. 89123
10300 W. Charleston #21 Las Vegas NV. 89135

Office: 702-489-3300
Fax: 702-410-9143

SYMPTOMS OF GROWTH HORMONE DEFICIENCY

	YES	NO
Changes in memory, processing speed and attention		
Lack of overall feeling of well being		
Depression		
Anxiety		
Social isolation		
Fatigue		
Decreased physical strength		
Central Obesity		
Decreased Bone density		
Decreased Muscle mass		
Impaired Cardiac function		
Neuromuscular dysfunction		
Insulin resistance		
Accelerated atherogenesis with increased carotid intima media thickness		
Increased LDL level		
Prothombotic condition		
Decreased thermoregulation/decreased sweating		
Low self esteem		
Fibromyalgia		

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Benefits of Testosterone Therapy

Testosterone is a hormone produced primarily in the testes. The possibilities of testosterone therapy are – increase your muscle mass, sharpen your memory and concentration, boost your libido, and improve your energy level. It helps maintain bone density, fat distribution, red blood cell production, and sperm production.

Testosterone increases muscle mass especially when combined with a resistance or training exercise program. More muscle mass and strength means better metabolism and higher quality of life. Most men report better recovery from their workouts and find that they can workout more intensely once started on testosterone replacement.

The increased metabolism resulting from increased muscle reduces fat and improves overall body composition. By reducing fat the risks of diabetes, hypertension, cancer, and heart disease go down.

A high concentration of testosterone receptors exists in the brain. Testosterone is essential for healthy brain function and can improve mood swings and irritability that many men experience as well as depression. Men sometimes display indecisiveness and loss of confidence with aging, both of which can be improved with testosterone therapy.

Testosterone has many cardiovascular benefits too. The highest concentration of testosterone receptors is in the heart. Which makes sense since the heart is a muscle that is contracting roughly every second. Testosterone improves blood flow by acting as a vasodilator and helps to repair damaged endothelium or inner lining of blood vessels. Testosterone can help lower blood pressure.

A higher level of well-being and a life brimming with more energy is commonly seen after testosterone replacement therapy.

TrimBody M.D.
Weight Loss/ Anti-Aging

9310 S Eastern Avenue, Suite 122
Las Vegas, NV 89123

10300 W Charleston Blvd, Suite 21
Las Vegas, NV 89135

Consent for HCG/Testosterone Replacement Therapy
Please initial on the line provided next to each paragraph

I, _____ the undersigned, request from TRIMBODY, M.D. and any of their medical providers to be prescribed HCG/Testosterone as a treatment of my medical condition.

_____I understand that this prescription for HCG/Testosterone is indicated for the treatment of Androgen Deficiency of the Aging Male (ADAM), sometimes called Andropause or Hypogonadism or HCG/Testosterone Deficiency, based upon my medical history, physical findings and laboratory tests.

_____I understand that TRIMBODY, MD, nor any of their medical providers are not able to guarantee any positive results or that there will be NO side effects or harm. The goal and potential benefit of therapy is to prevent, reduce or control the symptomatic dysfunction that occurs as a result of testosterone deficiency or the aging process and the low testosterone that occurs in aging males.

_____I understand that the conventional medical community and many Medical Providers believe HCG/Testosterone supplementation is contraindicated in a patient with a past history of prostrate cancer and/or Prostatic hypertrophy (BPH). I have been fully informed, and I am totally satisfied with my understanding that this proposed treatment may be viewed by the conventional medical community as new, controversial or detrimental and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

_____**FOR MALE PATIENTS:** While a study published in the New England Journal of Medicine, January 2004, reviewed 72 medical studies and found no evidence that HCG/Testosterone therapy causes prostate cancer,I understand that questions have been raised about testosterone as a cause of prostate cancer, since it is an anabolic hormone and can increase the growth rate of cancer cells.

_____I understand that side effects may occur with the use of HCG/Testosterone. Possible side effects may include oily skin, acne, moodiness, irritability, and slight bruising at the injection site, elevated hematocrit, exacerbation of sleep apnea, alteration of lipid profile, increased blood pressure and insulin resistance. I agree to cease using HCG/Testosterone and contact my provider if necessary, seek immediate medical attention in the event I knowingly develop any adverse side effects

_____**FOR MALE PATIENTS:** I understand that the use of exogenous HCG/Testosterone may result in a mild to moderate testicular atrophy and a lowered sperm count and that my ability to father children may be lessened.

_____ I understand the importance of maintaining a healthy lifestyle with the use of HCG/Testosterone and agree to continue with a recommended program of healthful nutrition, regular exercise, stress management and nutritional supplementation with the use of HCG/Testosterone. I further agree to continue any other hormone replacement therapies recommended by my health care provider.

_____ I understand that careful monitoring is crucial with HCG/Testosterone replacement therapy and agree to comply with the following monitoring recommendations while receiving HCG/Testosterone replacement therapy.

_____ I agree not to obtain any HCG/Testosterone medication from any source unknown by my prescribing health care provider.

HCG/Testosterone Replacement Therapy Protocol"

- Total and Free testosterone levels, PSA for male patients, CBC, Dihydrotestosterone and Prolactin are Measured initially, then again 3 months after the initial replacement. They are subsequently Repeated every 3-6 months thereafter or as required by my provider.

-PSA is measured with every lab draw in men over the age of 40.

-Other hormone levels may be monitored as well as other blood tests appropriate for treatment.

-Assessment for physical side effects will be done 6 weeks after the initial replacement and every 3-6 months thereafter or as required by my provider.

- Annually: Patient should have complete physical evaluation by their Primary Care Provider along with baseline blood testing and baseline prostate exams.

I understand the potential risks and contraindications associated with the use of HCG/Testosterone replacement therapy and that the alternative is to leave hormone levels as they are and do nothing.
I certify that I have read the above consent and fully understand it. I believe I have adequate knowledge upon which to base my informed consent. I fully understand what I am signing and hereby request to treatment using supplement exogenous HCG/Testosterone.

Patient Signature | Patient Name (Printed) | Date

Witness | Date

Patient's Name

Controlled Substance Questionnaire	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	____	____	____
Have you ever diverted a controlled substance to another person?	____	____	____
Have you ever taken a controlled substance that did not have the desired effect?	____	____	____
Are you currently using any drugs, including alcohol or marijuana?	____	____	____
Are you using any drugs that may negatively interact with a controlled substance?	____	____	____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	____	____	____
Have you ever attempted to obtain an early refill of a controlled substance?	____	____	____
Have you ever made a claim that a controlled substance was lost or stolen?	____	____	____
Have you ever been questioned about your pharmacy report or PMP report?	____	____	____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	____	____	____
Have you ever been accused of inappropriate behavior or intoxication?	____	____	____
Have you ever increased the dose or frequency of meds without telling your provider?	____	____	____
Have you ever had difficulty with stopping the use of a controlled substance?	____	____	____
Have you ever demanded to be prescribed a controlled substance?	____	____	____
Have you ever refused to cooperate with any medical testing or examinations?	____	____	____
Have you ever had a history of substance abuse of any kind?	____	____	____
Has there been any change in your health that might affect your medications?	____	____	____
Have you misused or become addicted to a drug, or failed to comply with instructions?	____	____	____
Are there any other factors that your practitioner should consider before prescribing?	____	____	____

Patient's Signature	Patient's Printed Name	Date
Parent/Legal Guardian	Parent/Legal Guardian	Date

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Patient Name: _____ Date: _____

PRESCRIBED MEDICATIONS & PREFERRED PHARMACY DISCLAIMER

TrimBodyMD offers a variety of medical weight loss and anti-aging programs, which may include prescribed medication(s) from an authorized and licensed practitioner, or medical provider.

TrimBodyMD is not a licensed dispensary of any prescription medications and TrimBodyMD does not sell or distribute any prescription medication(s), of any kind.

TrimBodyMD offers a variety of programs where our preferred pharmacy has approved cash pay rates, and TrimBodyMD incurs, as a courtesy to our patients on our programs.

Patients should be aware any medication(s) prescribed in our medical weight loss and/ or anti-aging programs may be available at a lower cost from another pharmacy of their choice. In the event a patient elects to use another pharmacy, the **price** of the TrimBodyMD medical weight loss and/or anti-aging program does not change; and patient assumes all costs and obligations associated their elected pharmacy.

Please indicate you understand the policy for medication(s) prescribed by a licensed and authorized provider of TrimBodyMD by initialing and signing below:

☐ **I have read and understand the above disclaimer regarding prescribed medication(s) and preferred pharmacy within the TrimBodyMD programs.**

☐ **I understand I can purchase any prescribed medications from another pharmacy of my choice and I am responsible for all costs associated with the prescribed medication(s) at the pharmacy of my choice.**

☐ **I understand using another pharmacy of my choice does not effect the price of the medical weight loss or anti-aging program I purchased from TrimBodyMD.**

Signature of patient _____ Date signed _____

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Patient Name: _____ Date: _____

Disclaimers & Waivers

FINANCIAL WAIVER

I understand the TrimBodyMD weight loss and anti-aging program(s) (and affiliated programs) all medications, supplements, cosmetic products & procedures, as well as certain elective injections will **NOT** be billed to an insurance company. I understand I am obligated for all charges incurred for these services, programs, products, and procedures; and payment is due **at the time services are rendered.** **I understand all services, programs, products, and procedures offered and or administered by TrimBodyMD are NONREFUNDABLE and considered FINAL.**

ELECTIVE INJECTIONS

I understand certain injections, such as vitamin injections and/or hormone replacement therapy injections, are considered elective and typically not covered by most insurance providers. Some examples of these elective injections may include, although are not limited to: Vitamin-D, B12, Alpha Lipoic Acid, Biotin, ect. I understand I am responsible for all charges incurred for these elective injections and payment is due at the time services are rendered.

CONTROLLED SUBSTANCES AND PRESCRIPTIONS

Controlled substance medications are closely monitored by various government agencies. Used properly, many medications under this classification can be highly effective for pharmacological therapeutic treatment of a variety of conditions. To ensure these medications are used correctly, I agree to the following:

1. **I understand TrimBodyMD is not a licensed dispensary clinic and therefore cannot sell, dispense, or distribute any medications.** ***(This excludes many of the dietary supplements included within the weight loss and anti-aging programs, such as Vitamin D and Vitamin B12).***
2. I am responsible for my own medication(s) and in the event a prescription or medication is lost, stolen or misplaced, or consumed sooner than directed by the authorized licensed medical professional, that prescription and or medication will not be replaced. TrimBodyMD will require an office visit and additional fees for services are required.
3. I will **NOT** request or accept a duplicate or similar prescription, whether considered a **controlled** substance or not, from another professional medical provider, for the treatment of any condition(s) TrimBodyMD is currently treating.
4. I understand requests for refills for renewals of prescription medications may take up to 72 hours for authorization. Therefore, I understand such requests should be made at least 3 business days in advance.
5. I understand to renew **controlled substance medications** will require an office visit, a fee for services rendered may be required, and such renewals are only made during office hours.
6. **I understand violating ANY of these terms may result in termination of patient care.**
7. As a courtesy, when requested, TrimBodyMD may store an injectable medication as a courtesy to our patients. Shall I request this courtesy, I again, acknowledge, TrimBodyMD is not a license dispensary clinic and the storing of this medication is strictly as a courtesy to me as a patient.

PRIVACY PRACTICES

I have received a copy of the Privacy Practices of this medical facility. I understand these practices can change over time reflecting changes in federal, state, and local laws, which TrimBodyMD extends its best efforts to safeguard Protected Health Information (PHI).

I have read and understand the disclaimers and waivers as stated above:

_____	_____	_____
Printed name of patient	*Signature acknowledging above*	*Date Signed*

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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VITAMIN CONSENT FORM

Vitamin Injections common side effects are included but are not limited to:

1.Risks: I understand there is risk of mild diarrhea, upset stomach, nausea, a feeling of irritation/warmth and bruising at the site of the injection.

2. I understand that although rare, Vitamin injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking vitamin injections should be aware of the possibility. These should be reported to your personal physician or walk in urgent care clinic immediately:

- **Rapid heartbeat /chest pain/ tightness**
- **Difficulty breathing and swallowing/shortness of breath**
- **Dizziness/confusion**
- **Hives, skin rashes**

By signing below, I acknowledge that I have read this informed consent and agree to the injections. I give consent to perform this and all subsequent VITAMIN Injections. I hereby release the doctor, the person injecting the VITAMINS and the facility from liability associated with this procedure.

Patient Signature_____ **Date** _____

Printed Name _____**Phone**_____

TRIM BODY M.D.™
WEIGHT LOSS / ANTI-AGING

NO REFUND POLICY

Here at Trim Body MD, we are committed to helping our clientele achieve results with whatever program they elect to participate in. However, there are many variables that determine a patient's success with any participation. Please be aware that you are paying for a service not a guaranteed result. There will be no refunds given whether or not you are satisfied with the outcome of your treatment.

By signing below, you acknowledge verification of this policy.

DATE:_____

PATIENTS NAME:_____ **(PLEASE PRINT)**

PATIENTS SIGNATURE:_____