Welcome!

Decalo Medical Group, LLC and entire medical, clinical and administrative staff would like to welcome you to our clinic and look forward to meeting you on your first visit. The weight reduction program here at Decalo is customized for each patient to best meet the individual needs of the patient. The programs take into account habits, lifestyle, medical history, allergies or intolerances, medications taken on a regular basis, special dietary needs, body composition, and the goals of each patient.

To help you prepare for your first visit, please read thoroughly and complete all of the forms in the new patient packet.

If you have any questions, please feel free to contact our office at 301-567-2557

We look forward to partnering with you in your weight loss program!

John K. Azíz, MD
Medical Director

New Patient Form Checklist:
To Be Completed, Read, and Signed on Your First Visit:

- □ Patient Intake Form
- □ Patient Informed Consent for Appetite Suppressants
- □ Medical Weight Loss Program Informed Consent Form
- □ Medical Weight Loss Consumer Bill of Rights
- □ Medical History

Thank you for your interest in DECALO Weight Loss Therapy. We work to understand the whole picture of our patients and therefore we ask for a significant history prior to the initial visit. Thank you for taking the time to complete this somewhat long form. We look forward to discussing the information you provide. 

Name: (Last)_____(First) _____(MI)___ Date: _____

Nickname/Preferred Name:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home) _____ (work) _____ (cell) _____

E-mail address: _____

Which would you prefer us to reach you by? (circle one): Home Phone, Cell Phone, Work, Email, Text

Age: _____ Date of Birth: _____ Gender: F _____ M _____

Highest Level of Education: (Circle One) High School/Associates Degree/ Bachelors degree/ Masters Degree/ Doctorate/ Technical school/ Vocational Program

Marital Status: _____

Occupation: _____ Hours per week working: _____ Retired?:_____

Employer: _____

Work Address: _____

How did you hear about DECALO Weight Loss Therapy ? _____

Were you referred to Decalo? If yes? By whom?_____ (please indicate their name and contact information i.e. phone number)

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Address: _____

The following questions will help us understand your expectations.

Why did you choose to come to DECALO Weight Loss Therapy?

_____
_____

What expectations do you have for this initial visit?

_____
_____

What long term expectations do you have regarding your weight?

_____
_____

What lifestyle habits do you currently engage in that you believe support your health?

_____
_____

ALLERGIES

- Are you hypersensitive, intolerant or allergic to:
- Any drugs, medications, injections?_____
- Any foods? _____
- Any chemicals or environmental substances?_____
- Have you ever had an allergy test? If yes, indicate when and explain:
  _____
  _____
- Do you have a primary care physician or an Internal Medicine doctor? Yes □ No □

CURRENT MEDICATIONS/ SUPPLEMENTS

Please list any prescription, over the counter (OTC) medications, or vitamins/ supplements you are currently taking and dosages:

Prescription Medications or Injections	**OTC Medications (Ibuprofen, NSAIDS, Antacids, sleep aids, laxatives)**	**Vitamins/ Supplements**
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.

PERSONAL PHYSICIAN

Primary Care Doctor's Name _____

Address _____

City, State: _____

Phone Number: _____

If no, when and where did you last receive medical care?

_____

_____

What are your most important health problems? List in order of importance:

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY

Please check all that apply:

_____High Blood Pressure
_____Chest Pain
_____Edema (Swelling of Legs)
_____Congestive Heart Failure
_____Previous Stroke or Heart Attack
_____Varicose veins or Venous Stasis
_____DVT or Pulmonary Embolus
_____Shortness of Breath
_____Snore
_____Daytime drowsiness
_____Sleep Apnea
_____Use CPAP or BIPAP
_____Asthma
_____Emphysema
_____COPD
_____Use of Home Oxygen
_____Diabetes – Juvenile
_____Diabetes – Adult Onset
_____Diabetes – Pregnancy
_____Always Thirsty
_____Cold Intolerance
_____Underactive Thyroid
_____Overactive Thyroid
_____Significant Hair Loss
_____ Pituitary Gland Disease
_____Adrenal Gland Disease
_____Kidney Disease
_____Gout
_____High Triglycerides
_____High Cholesterol
_____Gallbladder diseases

_____Irritable Bowel Syndrome
_____History of Colon Cancer
_____Hernias
_____Urinary Incontinence
_____Trouble Urination/ Male BPH
_____Frequent Urination
_____History of Prostate Cancer
_____Sexual Dysfunction/Low Sex Drive
_____Chronic Fatigue
_____Eats Ice Frequently (PICA)
_____Excess Facial Hair (if Female)
_____Abnormal Menstrual Cycle
_____Difficulty becoming pregnant
_____Polycystic Ovarian Syndrome
_____History of Breast Cancer
_____History of Ovarian or Uterine Cancer
_____Hot Flashes/Night Sweats
_____Trouble Falling Asleep
_____Trouble Staying Asleep
_____Depression - New Onset
_____Depression – Chronic
_____Bipolar Disease
_____Anxiety or High Stress
_____Migraine Headaches
_____Binge Eating
_____Bulimia or Purging
_____Anorexia Nervosa
_____Restless Leg Syndrome
_____Arthritis/Osteoarthritis
_____Lower Back Pain
_____Need Assistance Walking

_____Heart Burn/Reflux/GERD _____Numbness in Hands/Feet
_____Chronic Constipation _____Chronic Diarrhea

Any other medical or psychiatric problems not listed: _____

_____

- Do you have any known contagious diseases at this time? (please circle one) Yes □ No □

If yes, please indicate condition and how long?_____

PAST SURGICAL HISTORY

Previous Surgeries:
1._____4._____
2._____ 5._____
3._____ 6._____

OB/GYNE HISTORY (Females Only)

- Do you still have periods? Yes □ No □
- Have you had a Hysterectomy or tubal ligation? Yes □ No □
- Do you have regular monthly menstrual periods? Yes □ No □
- If no, explain:_____
- Are your periods heavy? Yes □ No □
- How many days do your periods last? _____
- Are you past menopause? Yes □ No □
- History of Miscarriages Yes □ No □
- Ectopic Pregnancies Yes □ No □
- Birth Control Yes □ No □
- How many children do you have? _____
- Number of Cesarean Sections? _____
- Number of Normal deliveries? (NSD/vaginal?)_____
- Number of children or grandchildren living with you? _____ Ages:_____

SOCIAL HISTORY

- Marital status: Married □ Single □ Divorced □ Widowed □ Separated □ Partnered □
- Do you feel like you have a supportive relationship? Yes □ No □
- History of abuse? Yes □ No □

- Have you ever smoked cigarettes? Yes □ No □ Amount per day: _____packs/day for _____years
- If you have quit smoking, when did you stop?_____

- History of drug or illicit substance abuse? Yes □ No □ Treatment? Yes □ No □
- History of alcohol abuse? Yes □ No □ Treatment? Yes □ No □

- Occupation: _____ Working Hours: _____hours/day
- Enjoy work? Yes □ No □
- Are you a student? Yes □ No □ If so, full time □ part time □

- Typical time you wake up _____ Typical time you go to bed: _____

- Hours of sleep each night? _____
- Do you sleep well? Yes □ No □ Awake well rested? Yes □ No □
- Do you need naps during the day? Yes □ No □
- If napping, for how long/how often? _____

- Do you work overnight shift? Yes □ No □
- What time do you wake up & go to sleep when working overnight? _____

- Main interests and hobbies? _____

- Do you exercise? Yes □ No □ If yes, what kind of exercise/ how often?
  _____
- Do you have a religious/spiritual practice? Yes □ No □ If yes, what?
  _____
- Take vacations? Yes □ No □
- Spend time outdoors? Yes □ No □
- How many hours of Television watched per day? _____
- How much time/day for relaxation? _____

- Do you have sufficient energy throughout the day? Yes □ No □

If not, when is energy best ? _____ Worst ? _____

WEIGHT HISTORY

- What is your high school graduation weight (age 18) _____
- Marriage Weight _____ Desired/Goal Weight_____
- Current Weight ?_____
- When did you begin gaining excessive weight? _____

DIET HISTORY

- Do you eat 3 meals/day? Yes □ No □ If not, how many? _____
- Which meals do you commonly miss?_____
- How many snacks do you eat per day? _____
- Do you graze throughout the day? Yes □ No □
- How many times do you eat out or pick something up to bring home? _____/week
- Are you a night time eater? Yes □ No □
- If so what do you normally eat?_____
- Are you a binge eater? Yes □ No □
- History of purging after you binge? Yes □ No □
- If yes, are you purging through exercise, vomiting, laxatives, or diuretics? Yes□ No□
- Do **you** do the majority of the grocery shopping? Yes □ No □
- Do **you** cook at home? Yes □ No □
- Do you or other people think you eat too fast? Yes □ No □
- Is your spouse, fiancée or partner overweight? Yes □ No □
- Do you have any overweight children? Yes □ No □
- If you are a vegetarian, what foods will you not eat?_____
- Have you used weight loss medications in the past? Yes □ No □ If yes, what did you take::_____

- If you have taken weight loss medications in the past, how long ago did you take it?_____months/years

- If you have taken weight loss medication did you experience side effects? Yes□ No□

If yes, please explain:

_____

_____

- If you have taken weight loss medication in the past, how much weight did you lose?_____ pounds in _____months/years

DO YOU DRINK?:

- Sweet Tea made with sugar? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Sweetened soft drinks/carbonated drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Diet or Zero Soft Drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Fruit Juices? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Fruit Punch? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Kool Aid? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Drink black tea, green tea, or coffee? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Energy Drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Whole Milk? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
- Do you have a sweet tooth? If yes, what sugar products and quantity per day or week products_____ _____/day _____/week
- Alcohol? Yes □ No □ If yes, □ Daily □ Few per week □ Special Occasions

If yes, what type of alcohol do you drink and how often?_____

FAMILY HISTORY

(Note: MGM- maternal grandmother; MGF – maternal grandfather; PGM- paternal grandmother; PGF – paternal grandfather; maternal – mother's side; paternal – father's side)

	Father	Mother	Siblings	MGM	MGF	PGM	PGF	Spouse	Children
Age if living									
Age when deceased									
Reason for death									

If this condition is in your family, please indicate which are prevalent and by whom in your family?

□ Obesity _____
□ High Cholesterol _____
□ Diabetes_____
□ Lung Disease/asthma/emphysema _____
□ Allergies_____
□ High blood pressure _____
□ Kidney disease _____
□ Heart Disease/stroke _____
□ Bleeding disorder _____
□ Cancer_____
□ Autoimmune Disorders_____
□ Osteoporosis_____
□ Psychiatric (depression, eating disorder, alcoholism) _____

PREVIOUS WEIGHT LOSS HISTORY:

Your diet history will be discussed during your initial visit. All efforts are relevant, even those with minimal or no weight loss. Please list all significant diet efforts for the past 5 years

Name of Diet or Doctor Program	Dates	Length of effort	Amount of Weight Lost	Weight Regained

_____ _____

Patient Signature Date

_____ _____

Office Personnel / Witness Date

THANK YOU FOR YOUR TIME AND EFFORT TO FILL THIS OUT. 

Informed Consent

Participation in a Weight Management Program

Patient Name: _____ Date of Birth: _____

When you decided to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight. The calorie deficit and portion-controlled diets are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary artery disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. They have been described and evaluated in many professional medical journals.

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem, eating activity and lifestyle patterns so your health care professional can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phases. We will not be able to release any medications, injections, products, supplements without an evaluation by the doctor or medical staff. We at Decalo Medical Group, LLC. will not be able to release your medications, injections, products, or supplements to any other individual. We are responsible for your care and your health is of utmost importance to us.
- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily food, activity, exercise, fluid and sleep diary, attending your consultations regularly if appropriate, and following your diet and exercise regimen.
- Allow your health care professional to share information with your personal physician.
- Make and keep follow-up appointments with your physician and have any blood tests taken or any other diagnostic measures made which your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by your health care professional and your physician.
- It is vitally important for you to advise the clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the clinic informed of any questions or symptoms you have, affords the best chance of intervening before a problem becomes serious.

If you do not have a personal physician, you must agree to find a primary care provider to assist in managing your medical care. Your signature represents your permission, understanding and commitment to the above commitments to the weight reduction program.

I. Procedures and Alternatives:

- I authorize Decalo Medical Group, LLC and clinicians/medical staff to assist me in my weight reduction efforts. I understand that my program may consist of a balanced low calorie diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual.
- I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that I think may be related to my weight control problem as soon as reasonably possible to the physician or medical staff treating me.
- 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 treatment will be dependent on my progress in weight reduction and weight maintenance.
- I understand the medical exam by the Physician is not a complete physical exam. I have been advised that I still need to consult with my Primary Care Physician for regular physical exams.
- I understand that Phentermine or any other weight loss medication should not be taken during pregnancy, due to the chance of damage to the fetus. This has 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 medication. If I become pregnant, I will advise both the clinic and my OB/GYN immediately.

II. Informed Consent for Appetite Suppressants:

- 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 indicated in the appetite suppressant labeling.

- 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 in the labeling. As a weight management physician, I have found the appetite suppressants helpful for periods in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, 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 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, 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 would be serious side effects. I believe that the probability of such side effects is outweighed by the benefit of the appetite suppressant use 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 the appetite suppressants use in this manner may give."

- I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight and significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
- I understand the purpose of this treatment is to assist me in a 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.
- I understand there are other ways 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 the appetite suppressant would also prove successful if followed.

III. Risks of Proposed Treatment:

The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatments may be necessary. In addition, it is conceivable other side effects could occur which have not been observed to date.

Reduced Weight: When you reduce your caloric intake to a level lower than the number of calories your body uses in a day, you will lose weight. In addition, your body makes other adjustments in physiology. In some participants, there have been rapid improvements in blood pressure and blood sugar levels. Other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, a slower heart rate, dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern, dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

Reduced Potassium Levels: The calorie level you will be consuming has been decreased and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume the regimented foo, fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities and more noticeably leg cramps, heartburn, nausea and vomiting. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

Gallstones: Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstones (pain, diagnosed stones and/or surgery) in individuals 30 percent or more over the desirable body weight not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 20-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not be aware of the condition. One study of individuals entering a weight loss program showed that as many as 1 in 10 had "silent" gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and for smokers. Losing weight, especially rapidly, may increase the chances of developing stones or sludge and/or increasing the size of existing stones within the gallbladder. Should any symptoms develop let your physician and health care professional know immediately. The most common symptoms of symptomatic gallstones are fever, nausea, vomiting and a cramping pain in the right upper abdomen. If you know or suspect that you may already have gallstones, please inform the medical staff during your consultations. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. There are medications which are currently available which may help prevent gallstone formation during rapid weight loss. You may wish to discuss these medications or your concerns with your primary care or weight management physician for more information.

Pancreatitis: Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol, the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications including death.

Pregnancy: If you become pregnant, report this to your health care professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take

precautions to avoid becoming pregnant during the course of weight loss. Your medications and injections must also be adjusted to prevent damage to the developing fetus.

Binge Eating Disorders: Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one study to increase binge eating episodes temporarily. Several other studies demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

Vitamins and minerals: Vitamins and minerals have been shown to cause side effects such as nausea, rash, constipation, and diarrhea. Advise your health care professional and/or physician if you are experiencing these side effects.

Thyroid Conditions: With weigh reduction programs and medications, side effects of vomiting, increased heart rate, chest pain, nervousness, tremors, menstrual irregularity, and/or nausea have also been associated with intake of medications and changes in the body weight.

- I understand that if I develop side effects from the weight reduction program, diet, medications, supplements, vitamins, injections, therapies or alternatives, I will discontinue the weight reduction program, diet, vitamins, supplements, injections, therapies, alternatives and/or the medication(s) and notify the medical staff as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (Please take your medications with you.)

IV. Risks associated with Being Overweight or Obese:

Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets have shown varying results for percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program. Recently published medical studies indicated people whose body weight fluctuates greatly or often have a higher risk of heart disease and death compared with persons of relatively stable body weight, and such weight fluctuations may play a role in the development of other chronic diseases.

Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient.

You have a right to leave treatment at any time although you do have a responsibility to make sure the physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

- I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies for high blood pressure, diabetes, heart attack, heart disease and arthritis of the hips, joints, knees, back and feet. I understand that these risks may be modest if I am not significantly overweight but the risks increases significantly with increased weight.
- I understand that thirty (30) to forty (40) percent of overweight or obese patients may have or develop gallstones. A large percentage of this group will develop symptomatic gallbladder disease during their lifetime. I understand that certain types of weight reduction programs may increase the chance of developing symptomatic gallbladder disease.

V. Potential benefits:

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:
• Lower blood pressure and/or reducing the risks of hypertension
• Lower cholesterol and/or reducing the risks of heart and vascular disease
• Lower blood sugar and/or reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see your physician as needed to have your need for these medications reassessed accordingly. Your health care professional will share your results with your physician on a regular basis so the physician is informed about your progress with your consent.

Other benefits may also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits, as well.

VI. Notice of Personal Health Information Practices (HIPPA Privacy Notice)

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

At Decalo Medical Group, LLC we are committed to treating information about you and your health responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective March 1, 2009, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information: Each time you visit Decalo Medical Group, LLC, a record of your visit is made. Typically, this record may contain your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among many health professionals who contribute to your care,
- A legal document describing the care you received,
- A means by which you a third party can verify that services were actually provided,
- A tool in educating health professionals,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decision when authorizing disclosure to others.

Your Health Information Rights: Although your health record is the physical property of Decalo Medical group, LLC, the information belongs to you. You have the right to:

- Inspect and copy your health record,
- Obtain an accounting of disclosures of your health information,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: Decalo Medical Group is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to Report a Problem: If you have questions and would like additional information, you can contact us at (301) 567 2557.

- I understand the HIPPA policy is available in the office and on the clinic web site for all patients to review.

KNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE : By signing this document, you acknowledge that Decalo Medical Group has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

- If there are any individuals with whom we are permitted to share your medical information, please provide their names(s) here: _____

Signature (Patient or Parent of Minor) _____

Date _____

VII. 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 if I am to be successful.
- I understand that I will not receive any refund for any treatment, medications, injections, or consultations if I am not successful. I understand that there is an initial fee, a fee every visit and a fee for products.
- I understand that I will not be able to return or receive funds for any product I purchase. It is my responsibility to inspect products before I leave the facility.

VIII. Financial responsibility:

Thank you for selecting Decalo Medical Group, LLC. for your Medical Weight Loss Management. Please be advised that payment of all services is due at the time services are rendered. We do not bill insurance companies for any medical weight loss services rendered Decalo Medical Group, LLC. For your convenience, we accept major credit cards, cash or flex spending accounts.

I have read and understand all of the above and have agreed to these statements. I understand that I will assume full financial responsibility for all services, medications, injections, products, supplements, vitamins or weight reduction programs rendered.

IX. Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1-2 percent of bodyweight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity will promote long-term weight loss. You have a right to ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components, receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, and examination, and know the actual or estimated duration of the program.

X. Resale of Products:

By signing this Informed Consent, you agree that you will not resell any medications, injections, vitamins, supplements, products and/or weight reduction program details purchased through this weight management program.

XI. Waiver of Childproof Containers

Federal regulations require packaging of most medications in child-resistant containers for households where young children are present. The purpose of the regulations is to prevent accidental ingestion. The child resistant containers for medications and nutritional supplements are available at your request. I understand that I must request these containers otherwise I will be given my medications in conventional packaging.

XII. Pregnancy Waiver

I am reasonably certain that I am not pregnant at this date and time. However, I hereby release Dr. John K. Aziz and the staff of Decalo Medical Group, LLC of any responsibility with regards to the possibility of my pregnancy during my weight reduction program. To my best knowledge, I am not currently pregnant

XIII. Topamax Waiver:

I understand that I may be prescribed Topamax or any other craving medications to be taken as directed by the physician or medical staff. I acknowledge that I have been informed by Decalo Medical group, LLC of the possible side effects of taking the Topamax or any other craving or weight reduction medication. I hereby release Dr. John K. Aziz and the staff of Decalo Medical Group, LLC of any responsibility should I choose to take the aforementioned medications as prescribed.

XIV. Injection Waiver

I understand that I may be prescribed injections which may include Lipotropic which includes sulfur. I acknowledge that I have been informed by Decalo Medical group, LLC of the possible side effects of the injectable which includes sulfur. If I have already indicated an allergy to sulfur and still request the Lipotropic injection to be given regardless of my allergy, I hereby release Dr. John K. Aziz and the staff of Decalo Medical Group of any responsibility should I elect to take the medication/injection.

XV. Pharmacy On site:

For your convenience we have a pharmacy on site to dispense any medication prescribed by Decalo Medical Group, LLC Clinicians. I have elected to have Decalo Medical Group, LLC fill my prescriptions. I have been made aware that written instructions are available with every prescription and to call 301-567-2557 in the event my prescription(s) have been incorrectly filled or for any questions/concerns.

XVI. Referral for Labs:

I understand that if I do not have lab work results with me today, I will still be treated and will be referred for tests to be done at a laboratory of my choice.

XVII. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if any 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 or weight loss medications. I acknowledge that I have been provided a copy of Notice of Privacy Practices. I, the undersigned, have reviewed this information with my health care professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.

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

Date: _____ **Time:** _____

Patient Signature: _____ (Or person with authority to consent for patient)

Witness/Staff Signature: _____

XVIII. Physician Declaration:

I have explained the contents of this document to the patient and have answered all their related questions to the best of my knowledge. The patient has been adequately informed concerning the benefits and the risks associated with the use of the appetite suppressants, weight loss medications, injectables, and vitamins or supplements, 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. I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have answered any questions posed by the patient. I fully attest that the patient/relative/guardian fully understands what I have explained and answered.

Physician Signature: _____

Date: _____