Pronto Medical Care
Carlos H. Fernandez, P.A.-C Daniel L. Turley, M.D |
515 Airport Rd Panama City FL, 32405
Phone Number: (850)704-5873 Fax Number: (850)807-5472

Weight Loss Program Agreement

- I understand and agree that the weight loss program at Pronto Medical Care is a self-pay program, and we are not obligated to file your medical insurance.

- I understand that the purpose of this treatment is to assist me in my desire to decrease my body weight/BMI and achieve a healthy weight loss.

- I acknowledge that there is no guarantee that I may receive weight loss medication if my health permits me from receiving it. Its important that your body is able to tolerate weight loss medication. Please be sure to report any and all health conditions and medications on your intake forms and to the attending physicians.

- I have agreed to and understand the weight loss visits are non-refundable. I will follow the guidelines of the program in which are as follows: 1st visit $250 (includes a visit with the physician, EKG w/interpretation, 2cc Lipo-Mino injection, order to have lab work done, dietary packet, appetite suppressant), 2nd visit $170 (includes a visit with physician, 1cc Lipo-Mino injection, appetite suppressant), and 3rd visit $170 (includes a visit with physician, 1cc Lipo-Mino injection, appetite suppressant). You may come weekly and get Lipo-Mino Injection for $40. The weekly injection does not include a visit with the physician.

- I understand in order to continue receiving appetite suppressants during the program it can be dependent on my progress in weight reduction and weight maintenance.

- I acknowledge in order to achieve maximum weight loss I must also follow a healthier eating style. In particular, a balanced calorie/carb counting program. (We will provide you with a packet that includes our recommended diet) It would also be beneficial for the participant to engage in daily physical activity. We recommend you engage in a minimum of 30mins-1hour of continuous exercise daily.

Patient's Name:_____

Signature:_____ Date:_____

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Patient Informed Consent for Appetite Suppressants

I, _____ (Patient's Name) DOB:_____
authorize Pronto Medical Care and its attending physicians to assist me in my weight loss efforts. I understand my treatment may involve, but not limited to, the use of appetite suppressants for 12 weeks.

Risk of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of appetite suppressants for longer than 12 weeks or taking the medication more than prescribed dosage indicated on the label can cause serious risk and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common but more serious risks are primary pulmonary hypertension and valvular heart disease. These and other possible risk could, on occasion, be serious or fatal.

Risk Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight/obese. Among them are tendencies to develop chronic health issues and life-threatening medical conditions. I understand these risks may be modest if I alter my weight and eating habits, otherwise the risk may increase significantly due to being overweight.

No Guarantees

I understand and acknowledge that in order to have successful and long-term weight maintenance I cannot solely rely on appetite suppressants. To achieve maximum results, it will involve a complete lifestyle change. My results will depend on my efforts and there is no guarantee or assurances that the program will be successful.

Medication Guidelines

The appetite suppressant being prescribed to you is only for the patient it's being prescribed to. You may not share, give away, or sell you prescription to anyone else. If you are in violation to this agreement it may result in automatic termination from the clinic and possible criminal charges. If you lose or misplace your prescription you may not receive another one until 1 month from the last original fill date. Please be sure to put you medication in a safe place away from children and pets or potential hazards.

Patient's Consent

I have read and fully understand this consent form and any questions I have concerning any process of the program or medications have been answered to my satisfaction. I will follow all guidelines of the medication and instructions of my attending physician. I understand the associated risk and factors of this agreement and agree to proceed.

Laboratory Results

We require that everyone in the program have general blood work done to make sure you don't have any underlying health conditions that could raise any concerns while in the program. If you have had any recent blood work done, we may use that, the physician will determine if its sufficient enough. If not, we will order blood work on your first visit that the patient will need to have done. Labs are not done in our office; they will need to be done at an outside laboratory at the patient's expense.

Health Care Provider Declaration:

All terms and conditions of this agreement have been read and reviewed by the patient participating in the program. I feel the patient has been adequately informed of risks and health factors, to the best of my knowledge they understand what they are participating in, including the use of appetite suppressants, the benefits and risks associated with alternative therapies and the health risks if they do not sustain a healthy weight. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated in this agreement.

Printed Patient's Name:_____

DOB:_____

Patient's Signature:_____Date:_____

Witness/Nurse:_____Date:_____

Physician's Signature:_____Date:_____

Lipo-Mino Protein Injection

Lipo-Mino injections claim to speed up the metabolism of excessive fat build-up when resistant to exercise, especially the stubborn body fats such as the hips, stomach, and inner thighs. The injections consist of unique and specially formulated ingredients known for their fat-burning qualities.

Pyridoxine (B6), Methionine, Inositol, Choline, B12, Cyanocobalamin, Thiamine, B1 50mg, Riboflavin B2

Lipo-Mino offers several benefits, not only for losing weight but also feel leaner, healthier, and more confident daily. Since various formulations and ingredients are commonly used in lipotropic injections, everyone reacts differently to supplements. In addition, the exact benefits will vary from person to person, depending on what formula they choose for their injectable, but generally, lipotropic injections can:

Boost the immune system
Control and lower cholesterol levels
Reduce and eliminate stored body fats
Enhance the metabolism
Increase alertness
Increase the energy levels
Improve the mood and mental clarity
Keep the skin healthy, nails strong, and hair shiny
Strengthen the nervous system

What Are the Possible Risks of Lipo-Mino?

All the ingredients in a lipo-Mino injection naturally occur in either the body or in food, but as with any treatment, there can be some risks. The following is the list of possible risks with Lipo-Mino:

Redness
Pain or bruising
Bleeding at the injection site (usually minimal and dissipate in a minimal amount of time)
Allergic reaction to the injections
Urinary problems (urge incontinence)
Diarrhea or upset stomach

If you are allergic to Lipo-Mino or any of its ingredients, please notify us beforehand.

Patient's Information

Patient's Name: (First)_____(Last)_____(M.I)_____

Address:_____

City, State: _____ZIP CODE: _____ Sex: Female Male

Date Of Birth:_____ Email Address:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Are you Single/Married/Divorced/Widowed/Separated? _____

Race: American Indian/ Alaskan Native/ Asian/ Native Hawaiian/ Pacific Islander/ African American/ White/ Declined
Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline Language: English Spanish Other: _____

Parent or Guardian (For Minor Child)

Name: (Last)_____(First): _____

Phone Number: _____

Emergency Contact

Name: (Last)_____(First): _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

How did you hear/Who referred you to our clinic? _____

HIPPA Acknowledgement and Consent Form

I understand that **Pronto Medical Care** originates and maintains paper/electronic records describing my health history, symptoms, examination findings, medical diagnoses, treatment plans, testing results, and any plans for future care.

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information and disclosures. I understand I have the following rights:

The right to review the notice prior to signing this consent.
The right to object to the use of my healthcare information for directory purposed.
The right to request restrictions as to how my health care information may be used.

I understand that **Pronto Medical Care** is not required to agree with my restrictions requested and refuse services. I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I Acknowledge that by refusing to sign this form or revoking the consent **Pronto Medical Care** and its providers may refuse treatment as permitted by **Section 164.506 of the Code of Federal Regulations.**

I acknowledge that as part of my treatment and healthcare operations it may be deemed necessary to disclose my healthcare information to another entity and I consent to such disclosure for these permitted uses including by fax, electronic recording, and paper record. I accept and understand the terms of this consent.

Printed Name:_____ **Date:**_____

Signature:_____

Disclosure to Family Members/Designated Guardians

I give permission for **Pronto Medical Care and its providers** to release my healthcare information, discuss my related care, any medical conditions, results, findings and care decisions with the following listed below. I understand that whoever I list will have access to my healthcare information.

Full Name	Relationship	Phone Number

PATIENT'S MEDICAL HISTORY

Patient's Name:_____D.O.B_____

What are you coming in for today? _____

Signs/Symptoms: _____

CIRCLE ANY PREVIOUS/CURRENT MEDICAL CONDITIONS LISTED BELOW

HEADACHES	MIGRAINE HEADACHES	OSTEOPOROSIS	GLAUCOMA
COLLAGEN VASCULAR DISEASE	HIGH BLOOD PRESSURE	EPILEPSY	HEMORRHOIDS
CHRONIC SINUS INFECTION	DIABETES	RED MEASLES	BRONCHITIS
COPD	MUMPS	SCARLET FEVER	THYROID DISEASE
CARPAL TUNEL	RHEUMATIC FEVER	ASTHMA	MITRAL VALVE PROLAPSE
SEIZURES, CONVULSIONS	POLIO	LUPUS	PERSISTENT COUGH
KIDNEY DISEASE	ENCEPHALITIS	HIV/AIDS	FIBROMYALGIA
RHEUMATOID ARTHRITIS	TUBERCULOSIS	PSYCHOSIS	OBESITY
GAIT ABNORMALITY	HIATAL HERNIA	POLYMYOSITIS	HEART DISEASE
ALCOHOLISM	PNEUMONIA	SHINGLES	HEART ATTACK
TRIGEMINAL NEURALGIA	SUBSTANCE ABUSE	CHRONIC BACK PAIN	ULCER
DEPRESSION/ANXIETY	CHRONIC NECK PAIN	BIPOLAR	STROKE
REITERS DISEASE	CROHN'S DISEASE	AMNESIA	CHICKEN POX
HEPATITIS	CANCER_____	BLADDER INFECTIONS	OTHER: _____
	STD'S	HPV	_____

Any Surgical History: **Yes or No** If yes, please list:_____

_____

Any Known Drug Allergies? **Yes or No** If yes, please list:_____

_____

Family History: **Adopted** **No Known Family History** **Please list any known conditions:**_____

_____

PLEASE CIRCLE YOUR ANSWER

USE OF ALCOHOL: NEVER RARELY MODERATE DAILY

USE OF TABACCO: NEVER PREVIOUSLY BUT QUIT(YEAR)_____ CURRENT PACKS PER DAY _____

USE OF DRUGS: YES OR NO IF YES, PLEASE LIST TYPE: _____

If you take any medications, please list:_____

_____