SCOTTSDALE
Weight Loss Center PLLC
Specialized Physicians. Proven Results.

Legal Name:_____

Name you prefer to be called_____

Date of Birth:_____**Age:**_____ **SSN:**_____**Sex: F M**

Address:_____**City:**_____**Zip:**_____

Home #_____**Cell#**_____**Work#**_____

Email:_____

Referred By:_____

Physicians:_____**Phone #**_____

CONTACT INFORMATION:

Contact #1_____ **Relationship:** _____

Cell#_____ **Work#** _____

Contact #2_____**Relationship**_____

Cell #_____**Work#**_____

Additional Emergency Contact:_____ **Phone#**_____

FINANCIAL POLICY:

- **Thank you for selecting Scottsdale Weight Loss Center for your weight management program. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept Visa, MasterCard, American Express, Discover Card, and personal checks.**
- **Any unpaid balance will accrue interest at the rate of 1.5% per month after thirty (30) days. In addition, a minimum charge of $25.00 will be assessed for any item return by the bank unpaid.**
- **In the event this account is referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. Jurisdiction and venue shall be in Maricopa County, Arizona.**
- **I have read and understand all of the above and agree to these statements.**

_____ **Date** _____

Signature of Patient

_____

Printed Name

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Medical History Form

PLEASE COMPLETE THIS FORM PRIOR TO YOUR FIRST VISIT

Date: _____ Nickname: _____

Legal Name: _____ Age:_____ DOB:_____ Sex: M F

Primary Care Physician: _____ Phone: _____

Other Physicians:_____

Whom do we thank for your referral to us? _____

Present Medical Status:

Any allergies to medications? Yes No
Please specify:_____

Are you taking any medications, vitamins, or herbals? Yes (please list below) No

Medication dose frequency	Medication dose frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you in good health at the present time to the best of your knowledge? Yes No
Please list all medical conditions, surgeries and hospitalizations:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History: (check all that apply)

_____ acid reflux	_____ alcohol abuse	_____ anorexia nervosa
_____ anxiety	_____ ankle/leg swelling	_____ arthritis
_____ asthma	_____ bone fracture (<90 days)	_____ bipolar disease
_____ bulimia	_____ cancer; type _____	_____ chronic pain
_____ depression	_____ diabetes; type_____	_____ drug use
_____ eye disease	_____ fatty liver disease	_____ glaucoma
_____ gout	_____ heart disease	_____ heart attack
_____ high blood pressure	_____ high cholesterol	_____ hyperthyroidism

Past Medical History (Cont.): (check all that apply)

_____ irregular heart beat	_____ kidney disease	_____ kidney stones
_____ liver disease	_____ low back pain	_____ migraines
_____ metabolic syndrome(pre-diabetes)		_____ palpitations
_____ polycystic ovary syndrome	_____ prior use of phen-fen	_____ sleep apnea
_____ snoring	_____ stroke	_____ ulcers
_____ valve disorder		

Surgeries:

_____ gall bladder removal	_____ appendix removal	_____ groin hernia
_____ hysterectomy	_____ coronary stent	_____ coronary angioplasty
_____ gastric bypass surgery	_____ lap band	_____ back surgery

Gynecologic History:

Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual Onset: _____
Duration: _____
Are they regular: Yes No
Pain associated: Yes No
Last menstrual period: _____
Hormone Replacement Therapy: Yes No
What: _____
Birth Control Pills: Yes No
Type: _____
Last Check Up: _____

Social History:

Have you ever smoked cigarettes or used other forms of tobacco? Yes No
If yes, how many packs per day?_____
Number of years smoked?_____
If quit, when?_____

Do you drink alcohol? Yes No
How many drinks per week?_____ [1 drink is: 1 glass wine(4 oz), 1 beer(12 oz), hard liquor (1 oz)]

What is your occupation?_____

Circle appropriate choice: Married Single Divorced Widowed Domestic Partner

Do you drink coffee or tea? Yes No How much daily? _____
Do you drink non-diet cola drinks? Yes No How much daily? _____
Any other sources of caffeine? Yes No How much daily? _____
How many hours per night do you sleep (on average)?_____

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Heart Disease/Stroke Yes No Who: _____
Diabetes: Yes No Who: _____
High Blood Pressure Yes No Who: _____
High Cholesterol: Yes No Who: _____
Kidney Disease: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____

Nutrition Evaluation:

Any history of binge eating, purging or starvation? Yes No

Do you eat more than 25% percent of your calories after dinner? Yes No

Present Weight:_____ Height (no shoes): _____ Desired Weight: _____

What weight you would be satisfied with? (For example, if you did not attain your desired weight, what weight would you accept?)_____

In what time frame would you like to be at your desired weight? _____

Birth Weight:_____ Weight at 20 years of age: _____ Weight one year ago: _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when?_____

How many diets have you been on (state the number)? _____

Previous diets you have followed:

_____
_____
_____
_____

Give dates and results of your weight loss:

_____
_____
_____
_____

What do you feel are your main reasons for being overweight?

_____
_____
_____

Is your spouse, fiancé or partner overweight? Yes No

By how much is he or she overweight? _____

How often do you eat out? _____

What restaurants do you frequent?_____

How often do you eat "fast foods?" _____

Who plans meals? _____ Cooks? _____ Shops? _____

Do you use a shopping list? Yes No

What time of day and on what day do you shop for groceries? _____

Food allergies: _____

Food dislikes: _____

Food you crave: _____

Any specific time of the day or month that you crave food? _____

Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

Do you awaken hungry during the night? Yes No
If so, what do you do? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

Typical Breakfasts	Typical Morning Snacks	Typical Lunches
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Typical Afternoon Snacks	Typical Dinners	Typical Evening Snack/Desserts
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Describe your usual energy level: _____

Activity Level: **(answer only one)**

___Inactive—no regular physical activity with a sit-down job.
___Light activity—no organized physical activity during leisure time.
___Moderate activity—occasionally involved in activities such as weekend golf, tennis, running, swimming or cycling.
___Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in running, swimming, cycling or active sports at least three times per week.
___Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior Style: **(answer only one)**

___You are always calm and easygoing.
___You are usually calm and easygoing.
___You are sometimes calm with frequent impatience.
___You are seldom calm and persistently driving for advancement.
___You are never calm and have overwhelming ambition.
___You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make: _____
_____
_____

How confident are you that we can help you with your weight problem? _____
_____
_____

Why is this the right time for you to lose weight? _____
_____
_____

Are there any other issues that you think are important that we should know? _____
_____

This information will assist us in assessing your particular problem areas and establishing your medical management plan. Thank you for your time, and patience in completing this form.

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Informed Consent

We want you to know...

When you decided to learn more about managing your weight, you took an important step toward improving your health. The physician 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 (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974. Similarly, helping modestly overweight patients attain and maintain a more cosmetically pleasing weight may appropriately, in and of itself, be considered a clinical response to weight loss treatment.

Over the past several decades obesity has moved from being considered a problem of gluttony to that of being an illness or a disease. It is now time to consider that it is not just a health problem but also a cosmetic problem worthy of being addressed on that basis.

Your role...

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 physician can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your physician has outlined for you, including assessment, treatment, and maintenance phases.
- Work with your physician and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your sessions regularly if appropriate, and following your diet and exercise prescription.
- Allow your physician to share information with your personal or primary physician.
- Make and keep follow-up appointments with your physician and have any blood tests taken or any other diagnostic measures made that your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by 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 healthcare professional and/or your 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 or primary physician, you must agree to find one before you and your bariatric physician begin working together. Your healthcare professional can assist you in this process if you like. Your signature below represents your permission, understanding and commitment to the above.

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, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, 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 primary physician as needed to have your need for these medications reassessed. Your bariatric physician will share your results with your primary physician on a regular basis so the physician is informed about your progress.

Other benefits may also be obtained, but cannot be guaranteed. Increasing activity level can favorably affect the above conditions and may have the additional benefit of helping you sustain weight loss. Weight loss and increased activity may provide important psychological and social benefits, as well.

Possible side effects...

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 ill effects occur, additional medical or surgical treatment may be necessary. In addition, it is conceivable that other side effects could occur, which have not yet been diagnosed or observed.

Reduced Weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. As a result of this weight loss, your body makes some other adjustments in body processes. Some of these adjustments are responsible, in some participants, for improvements in blood pressure and blood sugar. However, you also may experience other temporary side effects or discomforts, including an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism (the rate at which you convert food to energy), 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. Generally, 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 is 800 or more calories per day and it is important that you consume the calories that have been prescribed in your diet to minimize side effects. Failure to consume all of the food and 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. 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, as prescribed by your physician and/or primary physician, 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 desirable body weight (50 pounds or more overweight) 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 know it. 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 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. The most common symptoms of gallstones are fever, nausea and a cramping pain in the right upper abdomen. If you develop any of these symptoms or if you know or suspect that you may already have gallstones, let your physician and healthcare professional know immediately. 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. Drugs are currently available that may help prevent gallstone formation during rapid weight loss. You may wish to discuss these drugs with your physician or primary physician.

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 and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your bariatric physician and primary 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.

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 have demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The risk of weight regain...

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 that help to maintain 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 (including modified fasting) have shown varying results for patients who maintain weight loss. Some studies have shown that fewer than 5% of weight loss patients were able to maintain a reduced body weight after five years. Another study showed that after three years, weight loss patients, on average, maintained about one half of their initial weight loss. 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. A published medical study 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.

Sudden Death. 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.

Your rights and confidentiality...

You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure your personal physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

Resale of Products…

The Nestlé HealthCare Nutrition products purchased through this weight management program, including OPTIFAST®, OPTITRIM®, and others etc, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any Nestlé HealthCare Nutrition products or Scottsdale Weight Loss Center PLLC. products purchased through this weight management program and that you will continue to consult with your treating physician for so long as you are using such products, as it may be hazardous to your health to abruptly abandon the weight loss program without medical supervision.

Disclosure of conflict of interest

I understand that Scottsdale Weight Loss Center has a financial interest in the sale of meal replacements and other products. Treatment is not contingent upon the use of these products.

By signing this Informed Consent, you state:

I understand that the information about my treatment in the weight management program offered by the Scottsdale Weight Loss Center, PLLC is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. In order for the research, science and weight management industry to learn and benefit from my treatment, I give permission for information regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity. As part of my continued education, I consent to receive periodic emails from my physician that will contain valuable information and helpful tips to ensure my success in weight loss and maintenance.

I hereby certify that the patient has advised me that they have read and understand the consent form. The patient has had the opportunity to ask questions and have them answered.

_____ _____

Physician/Signature **Date**

I, the undersigned, have read and understand this information and have had an opportunity to ask questions. I will not sign this form unless I've had my questions answered to my satisfaction.

_____ _____

Participant Signature **Date**

I have received a copy of this signed consent form.

_____ _____

Participant's Initials **Date**

SCOTTSDALE
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Motivations

_____ **Date** _____

Name of Patient

List the advantages to losing weight

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Rate on a scale from 1-10 (1 being lowest, 10 being highest) and circle it:

1. Do you want to lose weight?

1 2 3 4 5 6 7 8 9 10

2. Do you think you can lose weight?

1 2 3 4 5 6 7 8 9 10

3. Do you think you can maintain your weight loss?

1 2 3 4 5 6 7 8 9 10

Weight Management and Wellness Questionnaire

Name_____ Date_____

1	Do you often eat standing up?	Yes	No
2	Difficult for you to remember everything that you ate today or yesterday?	Yes	No
3	Do you often eat between meals?	Yes	No
4	Do you tend to finish your food before others?	Yes	No
5	Do you often not use plates or utensils when eating?	Yes	No
6	Do you frequently do other activities while eating?	Yes	No
7	Is quantity of food more important than quality?	Yes	No
8	Do you tend to eat slowly?	Yes	No
9	Do you enjoy trying different types of food?	Yes	No
10	Do you love high-fat or high-sugar foods?	Yes	No
11	Do you pass on food that isn't tasty?	Yes	No
12	Is eating one of your greatest pleasures?	Yes	No
13	Is eating, dining out, or cooking your primary pleasure in life?	Yes	No
14	Are you a nervous or high-strung person?	Yes	No
15	Do you often snack when you're tense or uptight?	Yes	No
16	Is it hard for you to resist eating something that is right in front of you?	Yes	No
17	Is it difficult for you to relax?	Yes	No
18	Is the act of eating often more important than what you are eating?	Yes	No
19	Are you a worrier?	Yes	No
20	Is it difficult for you to be assertive?	Yes	No
21	Do you have upsetting dreams?	Yes	No
22	Do you often eat to avoid thinking about upsetting things?	Yes	No
23	Is it sometimes hard for you to identify your feelings?	Yes	No
24	Do you have problems that seem insurmountable?	Yes	No
25	Are you a people-pleaser?	Yes	No
26	Do you have special feel good foods	Yes	No
27	Does eating initially give you a lift or a high?	Yes	No
28	Do you often feel sad, bored, or down in the dumps?	Yes	No
29	Do you often plan out food treats for yourself?	Yes	No
30	Are you overly critical of yourself?	Yes	No
31	Do you lack energy or enthusiasm?	Yes	No

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The staff at Scottsdale Weight Loss Center would like to make you aware of our **Cancellation and No Show** policy.

- A "No Show" to a scheduled appointment with your Physician or Medical Assistant may be charged at the full appointment fee.
- Appointments with your physician cancelled with less than 1 business day notice may be charged $30.00.
- Appointments with your Medical Assistant cancelled with less than 1 business day notice may be charged $10.00.
- Continued "No Shows" may be considered a lack of commitment to your weight loss program. Our Patient Coordinator will contact you to help to resolve this problem.
- In addition, please arrive 5 minutes early for your appointment.

Thank you for your cooperation and understanding in our continuing efforts to better serve all of our patients.

Dr. Craig Primack, Dr. Robert Ziltzer, Dr. Melody Rodarte, Dr. John de Guzman, Dr. Paul Sarmiento, Dr. Katherine Duncan and the Staff at Scottsdale Weight Loss Center, PLLC.

I have read and agree to the Cancellation and No-Show Policy. My signature below authorizes you to charge my credit card for missed appointments as per this policy.

_____
Name (Printed)

_____
Signature

_____
Date

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Scottsdale Weight Loss Center, PLLC which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

_____

Signature of Patient or Patient Representative

_____

Print Name of Patient or Patient's Representative

_____

Date

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of Scottsdale Weight Loss Center. However, I could not obtain written acknowledgement because: (please check the appropriate box)

- ☐ Individual refused to sign this Acknowledgement
- ☐ Communications barrier prohibited obtaining written acknowledgement
- ☐ An emergency situation prevented obtaining written acknowledgement
- ☐ Other (please specify)

_____

_____

Signature of SWLC Associate

we created or received your protected health information in the course of providing care to you.

Your Health Information Rights:

Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our practice administrator at the practice's address set forth in this Notice. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites. If the information is stored off-site, we have up to 60 days to respond, but must inform you of this delay.

Request Amendment. You have the right to request that we amend your protected health information. You must make this request in writing to our practice administrator. The request must state the reason for the amendment.

We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although we are not required to agree to your requested restriction, if we do agree, we will comply with your request unless the information is needed for emergency treatment. Please contact our practice administrator as set forth in this notice to request a restriction.

Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; pursuant to your written authorization; for notification purposes; for national security or intelligence purposes; to correctional institutions or law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our practice administrator. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our practice administrator or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our privacy officer must be in writing. We will not retaliate against you for filing a complaint.

For More Information:

If you have questions or would like additional information, you may contact our privacy officer at 480-366-4400.

Scottsdale Weight Loss Center, PLLC
9989 North 95th Street
Scottsdale, Arizona 85258

Effective Date: 12/1/06

NOTICE OF PRIVACY PRACTICES

SCOTTSDALE WEIGHT LOSS CENTER, PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revised notice in a prominent location in our office and, upon request, will provide you with a copy of the revised notice.

Uses and Disclosures of Your Protected Health Information:

Treatment. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example – we may disclose your protected health information a specialist.

Payment. We may use and disclose your protected health information to obtain payment for the health care services we provide you or to determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health information to another health care provider, health care clearinghouse or health plan for their payment activities. For example – we may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We may use and disclose your protected health information to support our business activities. For example – we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information to another health care provider, health care clearinghouse, health plan or "organized health care arrangement" we participate in, for certain health care operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Appointment Reminders and Treatment Alternatives. We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or services that may be of interest to you.

Persons Involved in Your Care. We may use and disclose to a family member, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.

Notification. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.

Disaster Relief. We may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Research. We may use and disclose your protected health information for research projects – e.g., for a project studying the effectiveness of a treatment. Generally, such research projects must have been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Public Health. We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury or disability. If directed by the public health authority, we may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Communicable Diseases. If authorized by law, we may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.

Law Enforcement. If certain legal requirements are met, we may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

***Coroners, Funeral Directors, and Organ Donation*:** We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, we may use or disclose your protected health information for facilitating organ, eye or tissue donation and transplantation.

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, we may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.

Written Authorization. Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have used or disclosed your information in reliance on the authorization.

Food and Drug Administration. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

Inmates. We may use and disclose your protected health information if you are an inmate of a correctional facility and

CONSENT FOR ELECTRONIC COMMUNICATION
Scottsdale Weight Loss Center, PLLC

- I agree to be contacted by Scottsdale Weight Loss Center, PLLC via email or text in regard to my healthcare services. I understand that email and text messages are not secure forms of communication.
- I understand that electronic communication should NOT be used in the case of a need for emergency care.
- I understand that refusal of this consent for electronic communication will not affect my ability to obtain treatment.
- I understand that by providing an Email Address and Cellular Phone Number, I attest that I control access to information sent to this address.
- I understand that Scottsdale Weight Loss Center, PLLC will not solicit my Email Address or Cell Phone Number passwords, and I acknowledge that protecting passwords and maintaining it will be my sole responsibility.
- I understand that I may revoke this consent at any time by providing Scottsdale Weight Loss Center with a verification of my identity and requesting that my current email address and cell phone be removed from the system.

I understand that this service of electronic communication is offered solely at the discretion of Scottsdale Weight Loss Center, PLLC and may be withdrawn to any patient at any time.

I agree that I will read and abide by all the Terms of Use at Scottsdale Weight Loss Center, PLLC.

I understand this is not a request for release of my medical records.

☐ **I agree to the statements above and wish to have electronic communication sent to me by Scottsdale Weight Loss Center, PLLC.**

Receiving protected health information through non-encrypted email.
I understand that there may be some level of risk associated with sending the **non-encrypted information in the email and text, as they both** could be read by a third party. I understand that Scottsdale Weight Loss Center, PLLC will not be responsible for unauthorized access to my protected health information while in transmission, and will not be responsible for safeguarding this information once it is delivered to me. Knowing the above, I authorize Scottsdale Weight Loss Center, PLLC to send my protected health information to me **without encryption** (Initials).

Last Name: _____ First Name: _____

Date of Birth: _____ SSN (last 4 digits): _____ Phone: _____

Email:_____

Signature: _____ Date: _____

Please send this request to:

Lindsey Schmitt, Privacy Officer 9989 N. 95th Street Scottsdale, AZ 85258	If you have any questions, contact the Privacy Office at the address to the left.

CONSENT FOR ELECTRONIC COMMUNICATION
Scottsdale Weight Loss Center, PLLC

Office use only

☐	Consent received by:		Date:	
☐	Request completed by:		Date:	

REVOCATION OF CONSENT FOR ELECTRONIC COMMUNICATION

I no longer want Scottsdale Weight Loss Center, PLLC to send electronic communication to me.

Last Name: _____ First Name: _____

Date of Birth: _____ SSN (last 4 digits): _____ Phone: _____

/s/ _____ _____ Date: _____

Signature of Patient, Parent, or Legal Authorized Representative* Relationship to Patient

*May be requested to show proof of representative status.

Office use only

☐	Revocation received by:		Date:	
☐	Request completed by:		Date:	