YOUR FIRST APPOINTMENT

We value your time and want to help make your first appointment more efficient. Enclosed are a New Patient Information Form, a Medical History, and a Weight History. Please complete these forms and bring them with you to your first appointment.

Please read and follow these instructions:

1. Bring the completed forms to your firstvisit.
2. Please be on time. This allows us to make the best use of your time and is considerate of other patients. Being more than 15 minutes late will result in rescheduling your appointment. Please give at least 24 hours' notice for change or cancellation of your appointment.
3. We do not accept insurance. Payment is due at the time of service. We accept cash, check and all major credit cards.
4. We require that you have an EKG which will be done on your first visit. We ask that you do not wear lotion, body oil, Vaseline, or any other products that could make your skin feel oily. We need your skin clean and free of products the day of your first visit.
5. We will be doing a body composition analysis on your initial visit. This will give us your weight and BMI (Body Mass Index). Please wear shoes that are easy to take off.
6. We require blood work on all new patients. On your first visit, you will receive a prescription for these tests. Please get this blood work completed by your second visit. You will be responsible for any charges not covered by your particular insurance. To ensure the most accurate results, please fast for 12 hours prior to your blood draw. You should have nothing to eat during that time. Drink plenty of water and take your medications during your fasting hours. It takes 2 to 3 days for the results of your tests to be faxed to us, so please have your blood work done as soon as possible so Dr. Lizarraga can review the results with you at your second visit with us.

We look forward to meeting you. If you have questions, please call 520-868-1400.

"The weight is over!"

PATIENT INFORMATION FORM

Name: (Last)________________(First)________________(MI)______

Address:________________________________

City:________________State:____________Zip________

Home phone:________________Cell phone:________________

Birth date:________________Age:.________.Sex: M F Marital Status:________________

Social Security #:________________

In Case of Emergency:

Name:________________.Relationship:________________Phone:________________

Patient's Spouse:________________Phone: ____________

Family Physician:________________.Phone:________________

How did you hear about the weight loss clinic ________________________________

I agree that I have come to Main Street Family Practice to assist me in losing weight. I understand that by joining the weight management program I am agreeing to regular weekly visits, following the instructions I am given and that I will be responsible for full payment each month. For your convenience, we accept Cash, Checks, Visa, MasterCard, Discover, and American Express. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I am looking forward to being thinner and healthier and commit to my share of the work ahead.

I have read and understand and agree to the Financial Policy of Main Street Family Practice.

________________________________ ____________________

Patient's Signature Date

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MEDICAL HISTORY

NAME: ____________________

Do you have any of the following condition or have you had them in the past?

	NOW	PAST
Loss of Hearing		
Ringing In Ears		
Ear Infections		
Bad Vision		
Glaucoma		
Nose Bleeds		
Sinus Trouble		
Sore Throat		
Allergies		
Hoarseness		
Pneumonia		
Bronchitis		
Asthma		
Shortness of Breath		
Tuberculosis		
Heart Murmer		
Palpitations		
Irregular Pulse		
Swollen Ankles		
Chest Pain		
Loss of Appetite		
Indigestion		
Stomach Ulcers		
Diarrhea		
Constipation		
Bloody/Tarry Stools		
Hemorrhoids		
Hernia		
Gall Bladder		

	NOW	PAST
Sudden Weight Loss		
Liver Disease		
Back Pain		
Joint Pain		
Broken Bones		
Dizzy Spells		
Fainting Spells		
Memory Loss		
Insomnia		
Nervousness		
Depression		
Phobias		
Manic Depression		
Anxiety		
Schizophrenia		
Bulimia		
Anorexia		
Other Eating Disorders		
Frequent Urination		
Kidney Disease		
Kidney Stones		
Prostate Disease		
Headaches		
Migraines		
Fatigue		
Anemia		
Immune Disorders		
Alcohol Abuse		
Drug Abuse		

	NOW	PAST
Heart Disease		
Thyroid Disease		
Cancer		
Diabetes		
Stroke		
Osteoporosis		
Gerd		
Rashes		
Chicken Pox		
Mumps/Measles		
Polio		
Nausea		
Vomiting		
Stomach Ulcers		
Heartburn/Reflux		
High Blood Pressure		
High Cholesterol		
Hepatitis		
HIV/AIDS		
MRSA		
Seizure/Epilepsy		
Leg Cramps		
Gout		
Malaria		
Thyroid Fever		
Cholera		
Hypoglycemia		
Arthritis		

FAMILY HISTORY: IF A BLOOD RELATIVE HAS SUFFERED THE FOLLOWING, PLEASE INDICATE THE RELATIONSHIP

Heart Attack	
Cancer	
Hypertension	
Stroke	
Epilepsy/Seizures	
Arthritis	
Diabetes	
Obesity	
Glaucoma	
Other:	

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Have you ever been hospitalized or had surgery? If YES, when and why?

YEAR	ILLNESS or SURGERY

Please list all known chronic conditions or medical illnesses:

ALLERGIES: Please list any medications you are allergic to.
NOTE: Patients allergic to SULFA will receive the chromic chloride injection in place of the MIC/B-COMPLEX.

MEDICATIONS: Please list any medications you are currently taking regularly and as needed; Include over-the-counter medications.

MEDICATION	DOSAGE	HOW OFTEN	REASON

	YES	NO
Are you pregnant?		
Could you be pregnant?		
Are you breast feeding?		

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In the past year, have there been any changes in your family? Check all that apply.

- [ ] Marriage
- [ ] Separation
- [ ] Divorce
- [ ] Loss of job
- [ ] Birth
- [ ] Serious Illness
- [ ] Death
- [ ] Other
- [ ]

Do you take: Check all that apply.

- [ ] Vitamins
- [ ] Laxatives
- [ ] Hormones
- [ ] Pain Medication
- [ ] Stomach Medication
- [ ] Birth Control Pills
- [ ] Nerve Condition Cold
- [ ] Medication Herbal
- [ ] Supplements

Please rate the intensity of any of these symptoms you have had in the past.

0 = NO PROBLEM 1 = MINOR PROBLEM 2 = BIG PROBLEM

- [ ] Hunger
- [ ] Cravings
- [ ] Mood Swings
- [ ] Irritability
- [ ] Headache
- [ ] Feeling "wired"
- [ ] Skin Rash
- [ ] Diarrhea
- [ ] Constipation
- [ ] Hot Flashes
- [ ] Dizziness
- [ ] Dry Mouth
- [ ] Blurred Vision
- [ ] Excess Urination
- [ ] Rapid Heart Rate
- [ ] Palpitations
- [ ] Insomnia
- [ ] Anxiety
- [ ] Shortness of breath
- [ ] Difficulty urinating
- [ ] Excess thirst

WEIGHT HISTORY

Height:__________________ Current Weight:__________________ Goal Weight:__________________

How long have you been trying to lose weight? ______________________________

What has been your heaviest weight? ______________________________

When were you that weight? (at what age?) ______________________________

As best you can recall, what was your body weight at each of the following ages?

Grade School_______High School________College_______Ages 20-29________30-39_______40-49_______50-59 _______

At what age did you start trying to lose weight? ______________________________

What do you think is the cause of your weight problem? ______________________________

____

____

Have you ever stayed the same weight for 10 years or more? YES NO

Are any members of your household overweight? YES NO

If yes, please list relationship and details ______________________________

____

____

What is your motivation for wanting to lose weight? Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Perform better
- ☐ Feel more confident socially
- ☐ Reduce medications
- ☐ Upcoming event
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller size
- ☐ Upcoming vacation
- ☐ Look better
- ☐ Live longer
- ☐ Look more attractive for my partner
- ☐ Want to wear more stylish clothing
- ☐ Other (please describe)

____

What dietary problem areas apply to you? Check all that apply.

- ☐ Skipping meals
- ☐ Craving carbohydrates
- ☐ Large portion size
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Binging on food
- ☐ Eating foods too high in fat
- ☐ Eating too many meals in restaurants
- ☐ Eating for reasons other than hunger
- ☐ Eating before going to bed
- ☐ Making yourself vomit after meals

What weight loss programs have you previously participated in?

		RESULTS?	LENGTH OF PARTICIPATION?
	WEIGHT WATCHERS		
	JENNY CRAIG		
	SLIM FAST		
	ATKINS		
	SOUTH BEACH		
	LA WEIGHT LOSS		
	NUTRISYSTEMS		
	LINDORA		
	OVEREATERS ANONYMOUS		
	LIQUID DIETS (EG. OPTIFAST)		
	DIET PILLS: MERIDIA, XENICAL		
	DIET PILLS: PHEN-FEN, REDUX		
	OTC DIET PILLS		
	OBESITY SURGERY		
	OTHER		

Have you maintained any weight loss for up to one year on any of these programs? YES NO

What did you learn from these programs regarding your weight? ______

______

______

Why did these programs not meet your expectations? What did not work? ______

______

______

Please answer the following questions on a scale of 1 - 5.

SCALE: LEAST 1 2 3 4 5 MOST

- ☐ Your level of interest in losing weight is?
- ☐ Are you ready for lifestyle changes to be part of your weight control program?
- ☐ How much support can your family provide?
- ☐ How much support can your friends provide?
- ☐ How confident are you that you can lose weight this time?
- ☐ How confident are you that you can keep weight off this time?

FOOD ALLERGIES: ______

FOOD DISLIKES: ______

FOOD YOU CRAVE: ______

How much do you smoke daily? ____________________

How much caffeine do you ingest daily? ____________________

How much alcohol do you drink? ____________________

DO YOU

		TYPICAL FOODS	
	EAT BREAKFAST		
	EAT LUNCH		
	EAT DINNER		
	EAT BETWEEN MEALS		
	EAT AT NIGHT		
	EAT WHEN STRESSED		

ACTIVITY LEVEL (CHECK 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, jogging, swimming or cycling.
- ☐ Heavy activity - Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming, cycling or active sports at least 3 times per week
- ☐ Vigorous activity - Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

BEHAVIOR STYLE (CHECK 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

THIS INFORMATION WILL ASSIST US IN IDENTIFYING YOUR PARTICULAR PROBLEM AREAS. THANK YOU FOR YOUR TIME AND PATIENCE IN PROVIDING THIS INFORMATION.

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NOTICE OF PRIVACY PRACTICES

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.

Main Street Family Practice is required by Federal and Arizona law to maintain a record of the care and services you receive. We understand that this information about you and your health is personal, and we are committed to protecting the privacy and security of your health information.

This NOTICE OF PRIVACY PRACTICES (the "Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your rights to access and control your protected heath information. "Protected Health Information" (PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice applies to all your PHI maintained by Main Street Family Practice, whether the PHI is created by your treating Main Street Family Practice physician, by your referring physician, by a nurse, or by others working at/or with Main Street Family Practice physician, Main Street Family Practice is required by law to abide by the terms of this Notice In this regard, we are required by law to:

- Make sure that your PHI is private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this Notice as currently in effect.

REVISION OF NOTICE OF PRIVACY PRACTICES
We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all health information that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised notice at all Main Street Family Practice offices. We will also make paper copies of the revised Notice available upon request.

THIS NOTICE IS EFFECTIVE AS OF January 01, 2018.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION {PHI):

You have the following rights with respect to your protected health information:

Right to Request Restrictions: You may request that we restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations, or you may request a limit on the PHI we disclose to others who are involved in your care (i.e., a non- Main Street Family Practice, a laboratory) or in the payment of your care. We are not required to agree to your request; but if we do, we will honor it. Even if we agree to your request, your restrictions might not be applied in certain situations. For example, in an emergency, we may use or disclose the PHI, without any restriction, to provide

PATIENT PRIVACY QUESTIONNAIRE (HIPAA)

NAME: ____________________

Names and contact numbers of persons, if any, we may contact in an emergency.

____

____

If you would like correspondence from our office sent to an address other than your home please specify.

____

____

Are there any special instructions how correspondence may be sent to you?

____

____

Please provide an e-mail address we could send correspondence to: ____________________

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Please remember that cell phones, voice mail, and answering machines are not completely private.

Home phone: ____________________

May we leave a message on the answering machine? YES ___ NO _____

If someone answers your home phone may we leave a message with that person? YES _ NO _____

Cell phone: ____________________

May we leave a message on voice mail? YES ___ NO _____

Work phone: ____________________

May we leave a message on voice mail? YES ___ NO _____

Which of the above phone numbers should we call to confirm your appointment time? ____________________

SIGNATURE:____________________DATE: ____________________

PATIENT'S ACCOUNT NUMBER: ____________________

Note: This signed Privacy Questionnaire will remain in your file and will be considered current.
If there are any changes you must notify our office and complete another form.

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I,____DOB__________________

Dr. Dario Lizarraga, his associates and/or staff of Main Street Family Practice to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify and/or cancel my appointments and/or to tender payment for services on my behalf.

NAME: ------------------------------------

NAME: ------------------------------------

________________________________ ____________________

Signature Date

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Patient Informed Consent for Appetite Suppressants and Participation in a Weight Management Program

I. Procedure and Alternatives:

1. I,________________________________(patient) authorize Dr. Dario Lizarraga to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 8 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

2. 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 8 weeks) using the dosages indicated in the labeling."

, I have found the appetite suppressants helpful for periods far in excess of 8 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. At Main Street Family Practice, an appetite suppressant may be used in combination with other appetite suppressants and other supplements."

"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 could be serious side effects (as noted below)."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

INITIALS:_______________

4. 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 the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and other 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 likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressant's for more than 8 weeks and in higher doses than the dose indicated in the labeling is considered an "off label" use and involves some risks 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 risks could, on occasion, be serious or fatal.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and / or the medication(s) and notify the medical staff of Main Street Family Practice as soon as possible. I also understand that if the problem is worrisome or severe, I will go the nearest Emergency room or see my primary care physician as soon as possible. (Take your medications with you.)

II. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

III. No Guarantees:

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

IV. Pregnancy:

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify Main Street Family Practice.

INITIALS:____________

V. Payment, Insurance, Refunds & Prescriptions:

By consenting to treatment, I agree to pay in full for all visits and charges at the time of each visit.

I understand that your services are not reimbursed by insurance and that you do not provide or complete claim forms for insurance purposes. I understand that no refunds are given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience: however, I may request a written prescription for my weekly dose of my medication.

VI. Property of MainStreet Family Practice:

I understand that all written materials describing your program or any of its parts, all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, nontransferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of the Main Street Family Practice program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

INITIALS:________________

VII. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all 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. My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, severe manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those listed on my medical history form or those prescribed by Dr. Lizarraga. I agree to inform Dr. Lizarraga of any changes in my medications.

WARNING

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

DATE:______________________________ TIME:______________________________

PATIENT:______________________________ WITNESS:______________________________

VIII. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, 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.

____

Physician'sSignature

INITIALS: __________

WEIGHT-LOSS CONSUMER BILL OF RIGHTS

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight 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 healthful food choices and increasing physical activity, promote long-term weight loss.

Qualifications of this provider are available upon request.

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, examinations, and laboratory tests.

Know the actual or estimated duration of the program.

Know the name, address and qualifications of the physician, dietitian or nutritionist who has reviewed and approved the weight-loss program

Signature Date