Men & Women's Health Center

180 Sausalito Blvd
Casselberry, FL. 32707
407-936-7999

Date: _____/_____/_____

Last Name: _____ First Name: _____

Age: _____ D.O.B: _____/_____/_____

Address: _____

City/State/Zip: _____

Phone: _____ E-mail: _____

Occupation: _____

Employer: _____

Circle Status: Single /Married / Divorced / Widowed

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ANSWERING THE FOLLOWING QUESTIONS WILL GIVE US A BETTER UNDERSTANDING OF YOUR WEIGHTLOSS GOALS.

This part is important:

Our goals are to first address the issues that brought you to this office and
second, to offer you the opportunity of improved health, wellness and quality of life in the future.
Daily we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your weight.

1.How many inches of fat do you want to lose? And where?

_____
_____

_____

2.Have you tried to lose weight before?

Yes_____ No_____

3. Through your weight journey, has it been?

About the same: _____ Getting worse: _____ B: Getting Better: _____

What makes it worse? _____

What makes it better? _____

What have you done to change? _____

What have you all done that was of no help to lose the fat? _____

4. Have you had to, or feel you may need to make any positive changes in your life due to your weight?

(i.e., eat better, less alcohol or drugs, skipping meals, eating less, activity, exercise, refined carbs, etc.)

And if so, what?

_____

_____

5. Other Health Concerns (if any):

_____

_____

_____

6. Possible Contradictions:

Please check all symptoms you have ever had, even if they do not seem related to your weight concerns:

Pregnant? Yes ___ No ___

__Thyroid Problems __Cancer __Photo Sensitive __Liver Problems

__ Pacemaker/Heart Disease/Lymphatic Disease/ Stomach Ulcers

__ Kidney Problems/ Gallbladder Issues

__ Epilepsy/ Diabetes/ High Blood Pressure/ Hormone Imbalances

7. General History

Please check all symptoms you have ever had, even if they do not seem related to your weight concerns:

__Headaches __ Pins and needles in legs/arms __ Fainting __ Neck Pain

__Loss of smell __Numbness in fingers/toes __ Loss of balance __ Dizziness

__Buzzing/Ringing in ears __ Back Pain __ Nervousness __ Numbness in fingers/toes
__Loss of taste __ Upset Stomach __ Fatigue __ Depression

__Irritability __Tension __ Sleeping Prob. __Heart Burn

8. List any drugs you are taking: (prescription/non-prescription)

_____
_____
_____

9. Have you had any surgery? (Please include all surgery)

_____
_____
_____

10. On a scale of 1-10, (1 being very poor, 10 being excellent) describe your:

Eating Habits: ____ Acute Pain: ____ Chronic Pain: ____ Stress: ____ Musculoskeletal Pain: ____

Eat sugar: ___ Overeating: ____ Skipping Meals: ____Reducing Calories: _____ Exercise: ____

Energy: ____ Sleep: ____ Consuming caffeine: ____ Letting yourself go hungry: ____

General Health: ____

I consent to a professional and complete examination if needed & to any examination that the doctor deems necessary. I understand that any fees for service rendered is due at the time of service and cannot be paid later.

Patient Signature: _____ Date:_____

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Election and Consent of Services

Dr. Ross has been performing esthetic procedures over 11 years and has seen 1000's of patients with excellent results. His programs, such as **Lipo-Laser, Radio Frequency, Ultrasound Cavitation, High Frequency Ultrasound, Thermage, and Red-light LED (Ultra slim), E-Sculpt** assist in fat removal, weight loss, muscle toning and tightening**.** It is important to realize that these non-invasive procedures are not for everyone, and some will not be candidates for these programs.

Following the consultation, Dr. Ross will make the determination to see if you are a candidate for the programs our office offers. Based on your BMI, body fat weight, body fat percentage and other factors Dr. Ross will make his recommendations for your case. This may include other procedures to achieve a good outcome for you. Based on your examination, he will let you know if you should start treatment plans.

It is imperative to follow Dr. Ross's recommendations and follow through with what you must do outside the office as outlined in Patient's Responsibilities to achieve the best results.

These programs are designed to achieve the best results when done as described in the consultation. Following the scheduled appointments, you have set for certain dates and times is important to get the best results.

_____ _____

Patient Signature Date

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Acknowledgements

I understand and agree that Men & Women's Health Centers of Florida may take photos of my treatment for progress the purpose of monitoring my progress.

Initials: _____

I understand all services are payable on the day the consultation or I have planned with Men & Women's Health Centers of Florida

Initials: _____

I have read and understand and acknowledging that Men & Women's Health Centers of Florida has a "No Refund" policy for any treatments that have been rendered and you acknowledge this policy, however if you have unused treatments, we will be happy to refund you the money for the unused treatments.

Initials: _____

I have been instructed that, in order to see maximum results from my treatments, I shall comply with all requirements from the Patient Procedures and information relayed to me by Men & Women's Health Centers of Florida or Dr Ross.

Initials: _____

I understand that should I cancel and appointment, please try to notify us within 24 hours if possible.

Initials: _____

Please arrive at your scheduled appointment time as we are very busy and may need to re-schedule in you are late. If you are running late give us a call.

If you miss 2 appointments without notice (no shows or no calls) you will be taken out of the schedule for all your appointments and re-scheduled. This does not include re-schedules or unforeseen circumstances.

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Muscle Stimulation / Laser Treatment

PLEASE READ CAREFULLY!

These are not all absolute contradictions to our procedures, but if you have any, please let us know so that doctor can discuss them with you.

1. Pregnant, breast feeding, menstruation cycle
2. Heart / Cardiovascular disease including poor blood circulation
3. Liver or kidney disease/failure
4. Disease of the lymphatic system
5. Cancer (active or within the last year)
6. Severe high blood pressure (hypertension)
7. History of strokes
8. Metal implants or wearing a pacemaker or other electronic implants
9. Skin allergies or open wounds
10. Flu or colds (must postpone treatment until you feel better)
11. Varicose veins in area of treatment
12. Thyroid or basal metabolic disorders (thyroid must be stable if on medication)
13. Duodenum ulcers
14. Must **not** be on any diet medications, pills, etc.
15. Diabetes
16. Malignant tumors
17. Epilepsy

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE DOCTOR!

To the best of my knowledge, I have none of the above listed conditions.
If I do, I have discussed the condition with the doctor.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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Treatment Consent

Your treatment involves the application of one or more of the following treatments: weight loss, ultrasound and radio frequency or laser, LED, infrared, electrical stimulation. These treatments are safe, but like any medical procedure there are risks, and complications. The purpose of this consent is to make you aware of the nature of these treatments, so you can decide whether you want to go forward with the treatments.

You have been given a list of contraindications to these treatments and have indicated that I have no known contraindications to these treatments. We will review your medical history with you to determine if you have any contraindications to these treatments.

There are no know risks for any of the procedures we perform in the office except what you have been given and signed in the contraindication list.

Current alternative treatments, which may vary have their own risks, and include liposuction, mesotherapy, lipo-dissolve, surgery, dieting, or exercise, or do nothing. Eating properly and exercising will enhance the outcome of this procedure. We will instruct you on the foods to eat to begin a healthy lifestyle to aid you in achieving your goals.

I understand that the series of treatments that are being recommended for me to achieve the best results. Anything less than the prescribed series of treatments may not give you the results you desire. There are no guarantees concerning the results of this treatments. I understand that I must follow the pre-treatment, regular and post treatments prescribed by Central Florida Body Contouring for performing these treatments.

Failure to follow the outlined patient protocols may result in failure to achieve the desired results. There is no chance I am pregnant.

The consent has been explained to me and the risks, benefits, alternatives to these procedures, and have had all my questions answered about this procedure. There for I consent to having these treatments.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

HIPPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act-45 CFR Parts 160 & 164)

This authorization affects your rights regarding the privacy of your personal healthcare information. Please read it carefully before signing. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by my signing or not signing this release.

PLEASE CHOOSEONE OPTION: A or B

A. I hereby authorize Men & Women's Health Center, to use and/or disclose the protected health information described below for the purpose(s) of treatment, payment, enrollment, or eligibility for benefits will not affected by my signing or not signing this
release.

i.___ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

ii. ___ I hereby authorize the release of my complete health record with EXCEPTION of the following information:

a. Mental Health Records
b. Communicable disease (including HIV & AIDS)
c. Other (please specify) _____

If you checked either of the option above: I authorize Men & Women's Health Center or its Business Associates to release all information to the following family or friends.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

B. Do not discuss/release my medical records or private information to anyone (including family members) or any entity. This option is not available for our minor patients; we must have a written documentation indicating the adult caregiver(s) with whom we may discuss the child's care.

This authorization shall be in force until properly revoked by me at which time this authorization expires. To revoke my authorization, I must submit a Revocation of Authorization Notice to Men & Women's Health Center, ATTN: Medical Records. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law. Men & Women's Health Center and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPPAA, federal or state law.

_____ _____
Print Name: Patient or Personal Representative Relationship to Patient Date

_____ _____
Signature of Patient or Personal Representative Date