Men & Women's Health Center
180 Sausalito Blvd
Casselberry, FL. 32707
407-936-7999

Patient Information:

Name (First, Middle, Last): _____

Female _____ Male _____ Date of Birth: _____/ _____/ _____ Age: _____

Address: _____
City/ Zip

Cell #: _____ Home#: _____ Work#: _____

Martial Status: Married _____ Single _____ Divorced _____ Widowed _____

Occupation/ Employer: _____

Address: _____
City/ Zip

Email: _____ How did you hear about us? _____

Please Check any Complaints you have felt in the last 3 – 6 months:

☐**HEADACHES:**	☐Head feels heavy	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant/ Frequent
☐**NECK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**MID BACK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**LOW BACK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**L / R Shoulder:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**RIB PAIN**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**L / R Hip**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**ARM / HAND:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**LEG / FOOT:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent

Please Check any activities that make your complaints worse:

☐Sitting	☐Running	☐Sit to Stand	☐Climbing	☐Standing	☐Pushing/Pulling
☐Walking	☐Driving	☐Sleep/Rolling	☐Bending	☐Reading	☐Dressing/Shaving
☐Lifting	☐Housework	☐Computer Use	☐Exercising	☐Sports	☐Yard work/Gardening

Have you seen another doctor for your pain?

Medical Doctor / Specialist / Physical Therapy / Chiropractor:
Other: _____

*(Please check **ALL** issues whether present now or in the past)*

SKIN:
- ☐Rashes
- ☐Itching
- ☐Dryness

MUSCULOSKELETAL:
- ☐Muscle or joint pain
- ☐Stiffness
- ☐Back pain
- ☐Swelling of joints

NEUROLOGIC:
- ☐Dizziness
- ☐Fainting
- ☐Seizures
- ☐Weakness
- ☐Numbness
- ☐Tingling

EYES:
- ☐Vision Changes
- ☐Pain
- ☐Redness
- ☐Color changes
- ☐Hair / nail changes

HEAD:
- ☐Headache
- ☐Head injury
- ☐Neck Pain

EARS:
- ☐Decreased hearing
- ☐Ringing in ears
- ☐Earache
- ☐Drainage

RESPIRATORY:
- ☐Cough
- ☐Shortness of breath
- ☐Painful breathing
- ☐Blurry/double vision
- ☐Flashing lights
- ☐Specks
- ☐Glaucoma
- ☐Cataracts

NOSE:
- ☐Allergies
- ☐Discharge
- ☐Hay fever
- ☐Nosebleeds
- ☐Sinus pain

CARDIOVASCULAR:
- ☐High Blood Pressure
- ☐Chest Discomfort
- ☐Chest Tightness
- ☐Heart Palpitations
- ☐Shortness of Breath

GASTROINTESTINAL:
- ☐Heartburn
- ☐Change in appetite
- ☐Nausea
- ☐Change in bowel habits
- ☐Constipation
- ☐Diarrhea

History of Past Injuries Surgeries / Medications:
E.g. Date of Car Accidents, Sports Injuries, Slip / Falls, Surgeries, Medications & Reasons:

DATE:	REASON:
__/__/____	_____
__/__/____	_____
__/__/____	_____
__/__/____	_____
__/__/	

Medications currently taking (if any):

_____

_____

Allergies (if any):

_____

_____

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

By my signature, I understand and acknowledge that the Doctor(s) will treat my present health issues as they deem necessary. I also understand that all original records and diagnostic studies are the sole property of the clinic and will be maintained in the clinic for the required statutory term. If the patient is a minor, as the parent, guardian or authorized agent. I hereby give permission to the clinic and its doctor(s) to evaluate and provide treatment for the minor patient.

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. +
16. Diabetes
17. Malignant tumors
18. 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