WILLIAM D. Summers, MD
THE WEIGHT CLINIC
PATIENT INFORMATION FORM

PATIENT NAME: (LAST)__________________(FIRST) ____________(MI) _______

Name you prefer: ____________________________Gender:____________________

Patient Address: ____

City: ________________________________State: ____________Zip: _____________

Home phone:_________________________ Cell: _____________________________

Birthdate: ___________________________Age:_____________________________

Country of Birth:____________________Country of Parent's Birth: _______________

E-Mail: ____

Employer:_______________________________Occupation:____________________

Employer Address: ______________________ Phone:________________________

Social Security Number: ___________________ Drivers License #: _______________

In Case of an Emergency:

Name: ________________Relationship:___________Phone:____________________

Patient's Spouse: ______________________________Phone: ___________________

Referred By: ____

Financial Policy: Thank you for selecting Dr. Summers and The Weight Clinic for your health needs. We are honored to be of service for you. Please be advised the payment for all services will be due at the time services are rendered unless prior arrangements have been made. We accept Visa, Master Card, Discover Card, Debit cards and cash. I agree that all costs incurred collecting any unpaid debts relating to this account will be my responsibility.

Patient Signature: ____________________________ **Date:** _______ **Time:** _______

William D. Summers, MD

Gynecology and The Weight Clinic

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders. (THIS WILL ONLY BE DONE WITH INDICATED CONSENT)

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

[William D. Summers, MD] Duties

We are required by law to maintain the privacy of your protected health information and to provide you

with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Gwen Goodman, practice manager or Dr. William Summers. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. William D. Summers
52 Medical Park East
Suite 215
Birmingham, AL 35235

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

WILLIAM D. SUMMERS, MD
GWEN GOODMAN, PRACTICE MANAGER

Effective Date

This notice is effective on or after October 1, 2018

PATIENT SIGNATURE: ______________________________

DATE READ: ____________________ TIME: ______________

THE WEIGHT CLINIC

William D. Summers, MD
52 Medical Park East Drive #215
Birmingham AL 35235
205-838-3845 office
205-838-3845 fax

I,______________________________________(patient or guardian) do hereby authorize William D. Summers, MD and the staff of The Weight Clinic to assist me in weight reduction. I fully understand that this program shall consist of reduction in calories, an increase in physical activity and necessary lifestyle changes. Treatment may or may not include appetite suppressants and other supplements **I FURTHER UNDERSTAND THAT IN ORDER TO CONTINUE TO RECEIVE APPETITE SUPPRESSANTS, I MUST SHOW CONTINUED WEIGHT LOSS.**____________*initials*

I understand that I should discuss any and all management options to which I participate at The Weight Clinic with my primary physician. ___________________*initials*

I understand that I should not request/use a prescription appetite suppressant unless I have tried losing weight without medicines for at least six months utilizing calorie reduction, increased physical activity and attempted lifestyle changes.__________*initials*

I understand that there are currently 6 different classes of medicines approved for weight loss. I understand the stimulant medicines are for short term use only and that the maximum amount of time these may be refilled is five times (6 prescriptions) in a twelve month period per the guidelines of the Alabama Medical Board. This 6 month allowable duration is actually in excess of the three months recommended by the manufacturer. ________________*initials*

I understand there are potential risks involved with appetite suppressants. These may include, but not limited, to nervousness, headaches, high blood pressure, rapid heart beat and possibly skipped heart beats, constipation, sleeplessness, weakness, fatigue, dry mouth, and possible sexual dysfunction. I do understand that these possible side effects could be serious and potentially disabling.____________________*initials*

I understand that stimulant medicines (e.g. phentermine) can cause tolerance (dose doesn't seem to be as strong as it originally was) and that if this occurs increased doses can no longer be prescribed since this tolerance can lead to physical dependence and ultimately addiction.________________________*initials*

I will discontinue these medicines if I develop any worrisome or serious side effects and I will notify Dr. Summers/The Weight Clinic staff as well as my primary physician if any serious or concerning side effect occurs. ________________________*initials*

I will immediately stop any medicine and go to the closest Emergency Room if a side effect develops that is severe. ___________________*initials*

I understand that appetite suppressants are not required for weight loss and that calorie restriction, increased physical activity and lifestyle changes without the use of medicines will I produce the same results as those when medicines are used. ___________*initials*

I understand that before I am prescribed a stimulant medicine (e.g. phentermine) that I must meet specific qualifying measurements as per The Alabama Board of Medicine and that the stimulant class of medicines can only be refilled five times (6 total prescriptions) during any12 month period. _____________*initials*

I understand that it is a felony to give to others or take from others any controlled substances including those used in weight loss. ____________*initials*

I will not ask any other health care provider for any weight loss medicines of any kind while I am under Dr. Summers treatment for weight loss. _____________*initials*

I understand that if any other medicines from any provider are added/changed including dose changes in existing medicines, I will notify Dr Summers/The Weight Clinic staff to update my record with this information. .____________________*initials*

I understand that I may request to meet with Dr. Summers in person/private discussion, or with remote private video/ face-time or with phone contact anytime during my treatment. Urgency will determine priority exact daily timing for these contacts. There is no additional fee for this time with Dr. Summers ___________________*initials*

I do not have a history of alcohol or substance abuse. ____________*initials*

I do not have a history of an eating disorder. ________________*initials*

I do not have a history of manic-depressive disorder. ____________*initials*
I do not have a history of glaucoma. _______________*initials*

I do not have a history of schizophrenia. _____________*initials*

I understand that if I have had a sensitivity or reaction to any medicine, I will not use that medicine again and I do understand that an allergic reaction could occur using any medicine including appetite suppressants and supplements. ________*initials*

I have never had any significant medical issues with my heart and realize that if I am on any appetite suppressants and develop shortness of breath or chest pain I will stop the medicine immediately and notify Dr. Summers and my primary physician and go the nearest Emergency Room if these symptoms persist or seem serious. ________*initials*

I understand that if I am under the care of a pain management physician, that physician must provide written/verbal communication to Dr. Summers/The Weight Clinic staff authorizing consideration for Dr. Summers to include any prescription medicine that is a controlled substance in my treatment plan. I understand that I, the patient, must initiate and request the pain management physician to provide /submit this statement to The Weight Clinic which is a fundamental requirement with any pain management physician and with guidelines of the Alabama Medical Board. _______________*initials*

I understand that if I choose to use Lipotropic injections as part of my treatment plan I may go to any of Dr. Summers' clinics to have these administered by the staff on site. If I choose to take them home then I understand I must have proficiency in self administration or a qualified person who can administer them. I understand that potential adverse reactions including, but not limited to, generalized allergic reactions, injection site reactions with tenderness, erythema and induration; as well as burning and pain at the injection site may occur. I understand that I assume full responsibility for the prepared injections when I leave Dr. Summers' clinic. I will maintain, store and dispose of these syringes in a responsible and safe manner. ______________*initials*

I understand that it is highly recommended to have lab work obtained which could be brought/sent to The Weight Clinic if this has been done previously (preferred < 6 months). I understand that if this is done at my primary physician's office my benefits might cover this lab fee with no out of pocket charge. If it is more cost-effective or convenient I can obtain a lipid profile, comprehensive chemistry panel, a TSH (thyroid test) and a Hgb A1c for $45. This lab can be done at any of The Weight Clinic locations . I understand other lab values can be added to this analysis for an additional cost which should be discussed in advance. ________________*initials*

WOMEN ONLY: I am not pregnant or trying to get pregnant and understand that I must use adequate birth control if I am in the reproductive age and am treated with any appetite suppressant. I also understand that if I use the appetite suppressant Qsymia I must check a pregnancy test with each prescription since this medicine is known to be associated with birth defects. I understand that if an unexpected pregnancy does occur that I will stop any medicines or supplements immediately and notify Dr. Summers and your Obstetrician for immediate evaluation. ____________________*initials*

I realize that if I have lab drawn at The Weight Clinic I will get these results in the mail within 10 days and I will notify The Weight Clinic staff if I have not received them in my street mailbox . I understand that if I do no want any communication or mail sent to my house, I should obtain these results at Dr. Summers' clinic where they were collected. I will show/discuss any abnormalities from this report with my primary physician including any additional medications that Dr. Summers may have prescribed. __________*initials*

I understand that there is no guarantee that this program will work for me, but I understand that I must adhere to the program as directed to obtain the best results. By signing below, I certify that I have read and fully understand this consent form and the potential risks associated with my management for weight loss at The Weight Clinic.

Patient: ________________________________ Date: ___________ Time: _______

CIRCLE

It is okay to contact my cell number/preferred. **YES** **NO**

Cell number/ Preferred: ______________________

It is okay to send letters to my street mailbox. **YES** **NO**

It is okay to send information to my email address. **YES** **NO**

EMAIL: (optional)____

WILLIAM D. SUMMERS, MD
THE WEIGHT CLINIC

PATIENT MEDICAL HISTORY AND EVALUATION FORM

Patient Name: ______________________________

Date of Birth: ______________________________

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING INCLUDING DOSES AND HOW LONG YOU HAVE BEEN ON THAT MEDICINE

MEDICINE	DOSE	DATE PRESCRIBED

PLEASE LIST ANY KNOWN DRUG ALLERGIES:

____

____

____

PAST MEDICAL HISTORY

PLEASE **CIRCLE** ANY CONDITIONS THAT APPLY PRESENT OR PAST

ANOREXIA/ BULIMIA	GLAUCOMA	HEART DISEASE
ARTHRITIS	HYPERTENSION	KIDNEY DISEASE
ANXIETY	HIGH CHOLESTEROL	LUNG DISEASE
CANCER	HIGH TRIGLYCERIDES	LIVER PROBLEMS
DEPRESSION	HYPOTHYROID (LOW)	MIGRAINE HA
DEGENERATIVE DISC DIS	HYPERTHYROID (HIGH)	PULMONARY EMB
DIABETES	HEPATITIS	PCOS
DVT (BLOOD CLOT)	HEART ATTACK MI	SPINAL FLUID PRESSURE
EMPHYSEMA	HIV	SWELLING IN LEGS
EPILEPSY (SEIZURES)	HEARTBURN (GERD)	STOMACH ULCERS
FIBROMYALGIA	HYPERTHYROID DIS	TUBERCULOSIS
FAINTING	INFERTILITY	PREGNANCY PROBLEMS

PLEASE LIST ANY OTHER SIGNIFICANT HEALTH PROBLEMS:

____

____

____

PAST SURGICAL HISTORY

PLEASE LIST ANY PREVIOUS SURGERIES WITH DATES AND ANY COMPLICATIONS:

____

____

____

____

FAMILY HISTORY

CAN YOU LIST ANY MEDICAL ISSUES THAT OCCUR IN YOUR GRANDPARENTS, PARENTS AND SIBLINGS?

____

____

____

____

SOCIAL HISTORY

RELATIONSHIP STATUS: ______________________________

STUDENT? ______________________________

WORK >40 HOURS/WK? ______________________________

DOES YOU WORK ROTATE OR CHANGE SHIFTS? ______________

SMOKE? HOW MUCH/ HOW LONG? ______________

ALCOHOL? HOW MUCH? /HOW OFTEN? ______________

DO YOU DO RECREATIONAL DRUGS? YES NO

IF YES PLEASE INDICATE TYPE(S): ______________

WHAT PERCENTAGE OF YOUR MEALS DO YOU EAT OUT? ______________

ARE YOU THE PERSON IN YOUR FAMILY WHO BUYS GROCERIES? ______

SYSTEMS REVIEW

HISTORY WITH WEIGHT LOSS PROGRAMS/DIETS/MEDS

MAXIMUM WEIGHT LOSS ON ANY PROGRAM: ______________________________

MAXIMUM LENGTH OF PROGRAM YOU WERE ON? ______________________________

WHAT TYPE OF DIET HAVE YOU TRIED? ______________________________

HAVE YOU USED OTHER PHYSICIAN WT LOSS PROGRAMS? YES N0

WHICH, IF ANY, APPETITE SUPPRESSANTS HAVE YOU USED AND WHEN?

____

DID YOU HAVE A SATISFACTORY RESPONSE IF/ /WHEN USED? YES NO N/A

DID YOU HAVE ANY BAD SIDE EFFECTS IF MEDS WERE USED? YES NO N/A

DESCRIBE ANY NEGATIVE REACTIONS IF ANY EXPERIENCED:

____

____

WHAT WOULD BE YOUR DESIRED WEIGHT? ______________________________

TIME YOU EXPECT IT WILL TAKE TO REACH DESIRED WEIGHT? ______________

HOW MUCH WEIGHT HAVE YOU GAINED IN THE PAST YEAR?______________

WHAT IS THE MAIN REASON FOR YOUR DESIRED WT LOSS?______________

WORST FOOD HABITS? ______________________________

RATE YOUR ACTIVITY LEVEL: (1= INACTIVE to 10 = VIGOROUS > 4X / WK) __________

HOW MANY HOURS SLEEP DO YOU GET EACH NIGHT? ______________________

RATE STRESS LEVEL IN YOUR LIFE: (1= LOW to 10 = EXTREME) ______________

IN THE PAST MONTH HAVE YOU HAD ANY OF THE FOLLOWING?

CIRCLE ANY THAT APPLY:

GENERAL:
FATIGUE
WEIGHT CHANGE
MOOD CHANGE

MUSCLE/JOINTS:
NUMBNESS
SWELLING
WEAKNESS

EARS:
RINGING
HEARING LOSS

EYES:
PAIN
LOSS OF VISION
DOUBLE VISION
REDNESS

THROAT:
HOARSENESS
TROUBLE SWALLOWING
PAIN

NERVOUS SYSTEM:
HEADACHES
DIZZINESS
FAINTING
MEMORY LOSS

SKIN:
RASH
HAIR LOSS

GASTROINTESTINAL:
NAUSEA
HEARTBURN
VOMITING
CONSTIPATION
DIARRHEA
BLOOD IN STOOL
BLACK STOOL

HEME:
ANEMIA
ABNORMAL BRUISING
PROLONGED BLEEDING

CARDIAC/PULMONARY:
CHEST PAIN
SHORTNESS OF BREATH
FAST HEART RATE
FAINTING
SWELLING IN LEGS
COUGHING

PSYCHIATRIC:
DEPRESSION
EXCESSIVE WORRIES
TROUBLE SLEEPING
FREQUENT CRYING
POOR CONCENTRATION
ANXIETY
PARANOIA
RACING THOUGHTS
SEXUAL ISSUES

ANY CONCERNS NOT LISTED:
____
____
____
____
____
____

Do you have any current **health problems** that are **not listed** above? If yes, please discuss:

____

____

I CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY ABILITY. **I CERTIFY** THAT THIS INFORMATION IS ACCURATE AND I DID NOT OMIT / ALTER ANY OF MY HEALTH INFORMATION. I UNDERSTAND THIS INFORMATION IS USED WHEN DR. SUMMERS CONSIDERS OPTIONS FOR MANAGEMENT AT THE WEIGHT CLINIC. INTENTIONAL OMISSIONS AND INACCURACIES COULD EXPOSE ME TO SERIOUS AND UNNECESSARY RISKS.

Patient Signature:____

Date:________________________ Time:________________________

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES NO

NAME: ____

PHONE: ____

ARE YOU BEING TREATED FOR ANY CURRENT OR NEW ISSUES? YES NO

IF YES, COULD YOU DESCRIBE:

____

____

____

DO YOU HAVE A PREFERRED PHARMACY?

NAME:____

ADDRESS:____

PHONE:____

DR. SUMMERS DOES ENCOURAGE YOU TO HAVE RECENT BLOOD WORK(<6 MONTHS). YOUR INSURANCE MAY COVER THIS AT YOUR PRIMARY DR'S OFFICE. PLEASE HAVE ANY RESULTS SENT HERE. WE DO OFFER A LAB PANEL HERE FOR $45 CASH (THIS IS NOT BILLED TO INSURANCE.) THIS OFFER IS EXTENDED TO ANY PATIENT. THIS CASH PRICE MAY PROVIDE ADVANTAGE FOR THOSE WHO HAVE HIGH DEDUCTIBLES FOR LAB WORK OR FOR ANY WHO FIND IT CONVENIENT TO HAVE THIS COLLECTED WHILE IN THE CLINIC.