Patient Information Sheet

Please Print

Patient Full Name: _____
Last First Middle

Street Address:_____

City:_____ State:_____Zip _____

Mailing Address (If Different than above)_____

City:_____ State:_____ Zip _____

Home Phone: _____ Cell Phone:_____
Work_____

Age:_____ Date of Birth:_____ Sex:_____
Social Security #_____

Email Address:_____

Emergency Contact (Outside the Home) _____
Phone:_____

Signature of Patient :_____

AMS Rapid Weight Loss Center
Medical History Form

Dr. Steven Freeman, MD, PhD **Date** _____
Angie Bell, RN, FNP

Full Name _____ DOB _____

☐ Check here if you would like to receive special offers or confirm appointments by email
How did you hear about our weight loss center? _____
If a patient, please list their name

Medical History: (circle all that apply)

Diabetes	High Blood Press	Heart Disease	Bleeding	HIV/AIDS
Lupus	Thyroid Disorder	Leukemia	Anxiety	Cold Sores
Anemia	Circulation	Lung Disease	Seizures	Rosacea
Hepatitis	Liver Disease	Multiple Sclerosis	Insomnia	Fainting
Skin Cancer	Myasthenia Gravis	Stroke	Arthritis	Acne
Blood Clots	Infections	Kidney Disease	Depression	Hernias

Medications: (circle all that apply)

Tetracycline	Aspirin	Prednisone	Ibuprofen
Doxycycline	Plavix	Accutane	Birth Control
Minocycline	Steroids	Vitamin E	Methotrexate
Erythromycin	Retin A	Insulin	

Other: (Please list all **Oral and Topical Medications** including creams and ointments

_____

Allergies: (Circle all that apply)

Lidocaine	Sulfa Drugs	Adhesives	Shellfish
Penicillin	Betadine	Latex	

Other: _____

Surgical History: (Circle all that apply)

Hernia	Hysterectomy	Gastric Bypass	Heart Valve
Thyroid	Abdominal	Heart Bypass	Other: _____

_____

Primary Physician: _____ **Phone Number**: _____

Pharmacy: _____ **Phone Number**: _____

Do you smoke? _____ If yes, how many packs per day _____
Do you drink alcohol? _____ If yes, how much per day _____
Are you pregnant? Y or N Are you planning to get pregnant? Y or N

Signature _____ **Date** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of AMS Rapid Weight Loss Center's Notice of Privacy Practices. I may request an additional copy from the practice at any time. I understand that I may ask if any changes have been made in the Notice of Privacy Practices either each time I visit the office or by phone and if there have been any changes, the practice will provide me with a copy, upon my request.

Patient's Printed Name _____ Patient's Date of Birth _____

Patient's Address _____

Patient's Signature _____ Today's Date _____

If Applicable:

Printed Name of Patient's Representative/Guardian _____ Relationship to Patient _____

Representative/Guardian's Address _____

Representative/Guardian's Identification & Telephone Number _____

Representative/Guardian's Signature _____ Today's Date _____

Staff Witness/Title _____ Today's Date and Time _____

Upon request, a copy of this signed acknowledgement shall be supplied to the patient or the representative/guardian.

To Staff Member:

Once processed, this form MUST be placed in the patient's medical record. Be sure to photocopy any ID's supplied by the patient's representative. In the event of the patient's refusal to sign this acknowledgement, explain here and notify the provider.

Initial, Date, and Time:

_____

_____

Staff Witness/Title _____ Today's Date and Time _____

AMS Rapid Weight Loss Center

Authorization of Medical Treatment

Print Patient's Name _____ Date of Birth _____

Patient, Guardian or Legal Representative's Signature _____ Date _____

Consent to Release Protected Health Information for Treatment, Payment, and Healthcare Operations

I hereby authorize the responsible physician, Steven E. Freeman, M.D. and his staff members at AMS Rapid Weight Loss Center to release my personal protected health information for treatment of my health condition to any other physician or healthcare provider directly involved in my care and treatment. Direct involvement example: a specialist or hospital to which Dr. Steven E. Freeman has referred me to. Indirect involvement examples: a laboratory, physician of radiology or pathology.

I understand that Mental Health, Substance Abuse, and HIV/AIDS related treatment will require an additional release of information authorization, each time the information is requested for treatment purposes, except in an emergency treatment, as this is Dr. Steven E. Freeman's office policy.

I understand that AMS Rapid Weight Loss Center will make all attempts to protect my confidential protected health information at all times. When the practice discloses my information it will be "Need to Know" personnel and the "Minimal Amount of Necessary Information" to accomplish the purpose will be provided including for the purpose of billing, payment, and collections.

I understand that I can request at anytime an accounting of disclosure (release of information) for treatment, payment, or healthcare operations, as of the start date of August 9, 2010, for disclosures made after this date.

I hereby consent and authorize AMS Rapid Weight Loss Center to use my protected health information for healthcare operations, such as quality assurance, improvement, and healthcare oversight as required by Federal and State laws.

I understand that I may revoke this consent in writing at any time.

Print Patient's Name _____ Date of Birth _____

Patient, Guardian, or Legal Representative's Signature _____ Date _____

AMS RAPID WEIGHT LOSS CENTER
CONTROLLED SUBSTANCE PRESCRIPTION CONTRACT

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local and state government agencies. In our weight loss clinic these medications are used to increase metabolism and curb appetite. They are not simply to be used to "feel good". Because my physician is prescribing such medication for me to help manage my weight, I agree to the following conditions:

1. I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCES. If the bottle is lost, stolen, misplace, or if I use it up sooner than prescribed, I understand that it WILL NOT BE REPLACED.
2. I WILL **NOT** ACCEPT OR REQUEST ANY OTHER CONTROLLED SUBSTANCE FROM ANOTHER PHYSICIAN OR INDIVIDUAL WHILE I AM RECEIVING MEDICATION FROM THIS OFFICE. THIS IS ILLEGAL, AND MAY ENDANGER MY HEALTH.
3. REFILLS OF CONTROLLED MEDICATION ARE AS FOLLOWS:
    A. Refills of medication will be made only during regular office hours: Monday- Thursday 8:00am-5:00pm. REFILLS WILL **NOT** BE MADE AFTER OFFICE HOURS, WEEKEND OR HOLIDAYS.
    B. My prescription will not be refilled under **ANY** circumstances if I should run out early. It is my responsibility to take only the prescribed dosage on the prescription bottle and to keep track of the amount remaining.
    C. Refills will not be made an **"EMERGENCY"** suddenly because I realize I will be out of medicine tomorrow. I will call during the above mentioned hours
4. We have the right to terminate our relationship with you if you receive the same medication from another physician.
5. I WILL NOT MISUSE OR ALTER MY PRESCRIPTION. I UNDERSTAND THAT THIS IS A FEDERAL OFFENSE AND DR. FREEMAN AND/OR STAFF HAVE THE RESPONSIBILITY TO REPORT THIS TO LAW ENFORCEMENT OFFICIALS AND DRUG ENFORCEMENT ADMINISTRATION FOR INVESTIGATION.
6. I will keep my scheduled appointments to enable my physician to monitor my condition on a regular basis.
7. New patients must show adequate documentation of medical problems. AMS Rapid Weight Loss Center staff will use medical knowledge of my condition to determine the best weight loss plan for me.
8. I understand that if my account becomes delinquent, my care will become **SUSPENDED** until my account is paid in full.

I understand that if I violate the terms of this agreement I will be terminated by this practice.

_____ _____

Patient signature Date

_____ _____

Witness Signature Date

AMS Rapid Weight Loss Center
764 Saco Lowell Rd
Easley, S.C. 29640
Phone: (864-) 343-FAST (3278)
Fax: (864) 855-5561

Waiver of Liability

I have elected to seek medical treatment at AMS Rapid Weight Loss Center, the office of Steven E. Freeman, MD. And understand that I am personally responsible for the payment of all services rendered. Failure to pay for services rendered may result in collections, collection cost, and any legal fee for the collection of any monies owed for services provided.

Payment is expected as services are rendered unless prior financial arrangements have been made in advance.

_____
Patient/Guardian/Authorized Representative Signature
Date

_____
AMS Rapid Weight Loss Center
Date