Pensacola Physical Medicine, Inc.

Dr. Peter Smith, D.C.
Dr. Barbara Wade, M.D.
Lisa Della Ratta, A.R.N.P.
9007 University Pkwy. Pensacola, FL, 32514
Office: 850.476.5420 Fax: 850.476.5422

Patient Name____**Date**____________________

Address: ____ **Date of Birth**____________

Age_____ **Primary Care Physician:** _____________________ **Date of last physical/ labs**____________________

Email Address: ________________________ **Primary Phone Number:** _____________________________

Emergency Contact & Phone Number: ___________________________

Medical History: **Have you had the following diseases or conditions? If Yes, please write year of diagnosis**

Disease/Condition	No	Yes	Date
High Blood Pressure			
Heart Disease (heart attacks, heart failure)			
Stroke			
High Cholesterol			
Glaucoma			
Uncontrolled Asthma			
Emphysema			
Thyroid Disease (Hyperthyroidism Hypothyroidism)			
Neurological Disorder			
Seizure/Epilepsy			
Anorexia/Bulimia			
Anxiety/Depression			
Drug/Alcohol Abuse			
Kidney Disease			
Liver Disease			
Anemia or other blood disorder			
Blood Clotting Disorder			
Diabetes			
Cancer			
HIV			
Autoimmune Disorder			
Pregnant			
Breastfeeding			

List Any Allergies to Medications

Daily Medications and Supplements

Name	Daily Dosage

Hospitalizations/Surgeries

Year	Reason

LMP: ________________

Pregnancies

Year	Complications?

Tobacco Use: Yes or No: (if Yes) How Much___________ How long________________
Alcohol: Yes or No: (if Yes) How Much ______________/Day or Week
Illicit Drug Use: Yes or No (if Yes) Type ________________

Phentermine Weight Loss Program Informed Consent

Please read and initial each sentence after you review:

1. I have presented to the clinic for a consultation for weight loss management using Phentermine (if I qualify) along with an individualized diet and exercise plan. *Initial*___
2. Prior to treatment, I have fully disclosed any medical condition(s) in which Phentermine would not be a safe choice for my weight loss program. *Initial*___
3. These medical conditions have been provided to me in the weight loss package which has been reviewed by the clinician. *Initial*___
4. I understand that if I fail to disclose any medical condition(s), I release the facility which is known as Pensacola Physical Medicine, Dr. Barbara Wade, Lisa Della Ratta, NP, & Dr. Smith from all liability. *Initial*___
5. I have been fully informed of the benefits & risks of taking Phentermine. I understand that there is no guarantee for the effectiveness of Phentermine. *Initial*___
6. I understand that the treatment received by the clinician at Pensacola Physical Medicine CANNOT replace my regular primary care physician nor any specialists where I may be a current patient. *Initial*___
7. I understand that I must have current labs that are no older than 12 months. *Initial*___
8. I agree to sign a record of release of these labs from my primary care provider. *Initial*___
9. I understand that labs can be ordered at Pensacola Physical Medicine if I do not have a current provider. *Initial*___
10. I understand that I may quit the program at any time. While side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact the clinic immediately or if urgent, go to the nearest ER/call 911. *Initial*___
11. I have read and understand the above terms. All questions have been fully addressed to my satisfaction. *Initial*___

____________________	____________________	____________________
Patient Signature	Provider Signature	Date

Pensacola Physical Medicine strongly encourages you to consult with your primary care physician regarding initiation of our weight loss program. Our goal is for a successful outcome and your health is very important to our clinic.

PATIENT REGISTRATION AND PRIVACY INFORMATION

1.) I request Pensacola Physical Medicine to assist me in my weight reduction efforts.

2.) I am aware that the F.D.A. recommends that Phentermine should to be used as an appetite suppressant on a short-term basis along with a comprehensive weight loss program.

3.) I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that may be related to my weight control program as soon as possible.

4.) I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5.) I understand this authorization is given with the knowledge that the use of the appetite suppressants involves some side effects. The more common include dry mouth, constipation, or nervousness, elevated blood pressure and heart rate.

6.) I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Conduct normal healthcare operations such as quality assessment and improvement activities

Patient Name: ______________________________ Date: ______________

Signature: ______________________________

Provider Signature: ______________________________
Lisa Della Ratta DNP, FNP-BC

Phentermine Weight Loss Program Patient Information

Contraindications and Warnings:

Patients with the following should NOT use Phentermine:

1. An allergy to Phentermine
2. Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
3. Diagnosed with any of the following:
   a. Advanced arteriosclerosis
   b. Cardiovascular disease (Heart Disease)
   c. Moderate to severe hypertension uncontrolled
   d. Hyperthyroidism
   e. Glaucoma
   f. Liver Disease
   g. Kidney Disease
   h. Cancer
   i. Seizures or any Neurological Disorders
   j. Uncontrolled Depression and/or Anxiety
   k. HIV or Autoimmune Diseases
   l. Bleeding Disorders
   m. Uncontrolled Asthma
   n. Emphysema
   o. Drug and/or Alcohol Abuse
   p. Stroke
   q. Pregnancy or planning to become pregnant
   r. Breastfeeding

Pensacola Physical Medicine, Inc.

Dr. Peter Smith, D.C.
Lisa M. Della Ratta, A.P.R.N.
9007 University Pkwy. Pensacola, FL, 32514
Office: 850.497-6072 Fax: 850.476.5422

NO – SHOW and CANCELLATION POLICY

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's visit. Since appointments at our clinic are in high demand, we value advanced notice from our patients who are unable to keep their appointments.

To decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our practice, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made at least one full business day before the scheduled appointment. Patients will not be charged for an office visit if cancellation is made 24 hours before their appointment.

In the event an appointment is missed or cancelled with less than 24 hours within the practice working hours, with notice or without notice a $25 charge will be billed to the patients. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-provider relationship. **Again, all no-shows or same-day cancellations will be charged $25 if not cancelled with a 24-business hour notification.**

Finally, by signing this agreement you acknowledge that you have had an opportunity to review this agreement. **Pensacola Physical Medicine** reserves the right to modify any policies without notice.

I, ______________________________, understand the importance of notifying **Pensacola Physical Medicine** at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $25.

I understand that I will be charged a No-Show fee of $25 for failing to call and failing to show for my scheduled appointment.

I, ______________________________, give **Pensacola Physical Medicine** the authorization to charge my credit card $25 for each missed appointment where 24 hours' notice is not given. . I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when **Pensacola Physical Medicine** services rendered have ended, this form shall be shredded once I have terminated treatment.

Name on card: ______________________ **Patient Name:** ______________________

Card Number: __________ - __________ - __________ - __________

Expiration Date: ______ / ______ **Code:** ______ **Zip Code:** __________

Email address for receipt: ______________________________

Patient (or Parent/Guardian)/Card Holder Signature: ______________________ **Date:** ________

Please Print Name: ______________ **Signature:** ______________ **Date:** ________