Integrative, LLC Weight Loss Program
10404 W. Coggins Dr. ste#118
Sun city, AZ 85351
Phone: (623) 972-1055
Fax: (623) 972-1185

Patient Registration Form

Today's Date: _____

Patient information

Date of birth: _____
Patient's name: (Last) _____ (First)_____

Age_____ Height_____ Weight_____ Sex: M____ F ____

Street Mailing Address:

_____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

How did you hear about us

Clinic because/referred to clinic by: Doctor. ____ Current Client:____ Walk-In:____

Family Friend:____ Close to home/work:____ Internet:____ Other:_____

Case of emergency

Name of local friend or relative: _____

Relationship to patient: _____

Home phone: (_____) _____ Cell phone: (_____)_____

Medications

Current medications & dosages:_____
_____
_____
_____
_____
_____
_____
_____

Do you have any Allergies to medications? ____ Yes ____ No
If so which drugs: _____

Financial Policy

Thank you for choosing. Dr. Anita Dai for your Weight Loss needs provider. We are honored to be of service to you and your family. Above information is true to the best of my knowledge. I understand that I am financially responsible for any balance owed. I understand my insurance doesn't cover any part of The Weight Loss Program.

Sign: _____ Date: _____

Integrative Care, LLC Weight Loss Program Consent Form

I _____ authorize Dr. _____ and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, lipotropic injection, B12 injection or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that it is a FEDERAL FELONY to use diet pills for any non-medical purpose. Therefore, anyone that is found using appetite suppressants for energy or other purposes will be permanently discharged from the weight loss program.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death.

I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain. 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. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concern the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

I understand my insurance **doesn't cover any part of Weight Loss Program.**

Sign Name:_____ Date:_____

Patient (Or person with authority to consent for patient)

Provider:_____ Date:_____

Integrative Care, LLC

Lipotropic Injections Consent Form

I have been informed of the following:

While all components generally have no side effects, doses must be taken at regular intervals. The injections are only effective temporarily. As soon as the effects of these drugs wear out, the body starts returning to normal.

Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.

Some people have experienced allergic reactions to the injections.

Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pains.

Lipotropic injections change the function of the digestive system temporarily. This can result in extreme exhaustion.

Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.

Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

I have read the above and I agree to accept the risk of procedure. All my questions have been answered to my satisfaction. I agree to release the facility and the medical practitioner from any liability arising from the procedures. I consent solely to arbitration as a legal means of settlement.

Sign Name:_____ Date: _____

Provider:_____ Date:_____