

Healthy Solutions Medical Weight Loss

Bert Morales, M.D.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

PLEASE REVIEW IT CAREFULLY

*The Health Information Portability And Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

*As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose this information.

*We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

*Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

*Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending unpaid bills for services provided to a collection agency.

*Health care operations include the business aspects of operating our practice, such as conducting quality assessment and improving activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

*We may also create and distribute de-identified health information by removing all references to individually identifiable information.

*We may contact you to provide appointment reminders or information about treatment alternatives, or other health related benefits and services that may be of interest to you.

*Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

*You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

*The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.

*The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or locations.

*The right to inspect and copy your protected health information.

*The right to receive an accounting of disclosures of your protected health information.

*The right to obtain a paper copy of this notice from us at your first service date.

*The right to provide written acknowledgement that you received a copy of our "Notice Of Privacy Practices".

*We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties, and privacy practices with respect to protected health information.

*This notice is effective April 1, 2003 and we are required to abide by the terms of this notice. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we possess. We will post any changes in our office, and you may request a copy of the changes at any time.

*If you feel that your privacy protections have been violated, you have the right to file a complaint with us, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

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(PLEASE PRINT)

PATIENT INFORMATION:

Name: _____ DOB: _____

Age: _____ Sex: _____

Address: _____

City/State: Zip: _____

Home Phone (____) _____ Work Phone: (____) _____

Cell Phone (____) _____

Email Address: _____

Primary Care Physician: _____

Primary Care Physician Contact Number: _____

Date of Last Physical: _____

Occupation: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship: _____

Address: (If different from above) _____

Contact Phone Number: _____

Who may we thank for referring you? _____

Healthy Solutions Medical Weight Loss

Name: _____ Date: _____ Age: _____

1. How old were you when you started gaining excessive weight? _____
2. Are you aware of any medical reasons for your weight gain? Y / N
3. Is your weight now stable? Y / N Are you continuing to gain weight? Y / N
4. What prior attempts have you made to lose weight? _____
 - a. What were the results? _____
5. What do you think will be the benefits of your weight loss? _____
6. **Current weight:** _____ **Goal weight:** _____ **Height:** _____

Are you taking of medications, herbal therapies, non-prescription drugs, etc: Y / N

If yes, list: _____

Do you have allergies to any medication? Y / N If so, describe: _____

History of hypertension (high blood pressure)? Y / N

History of cardiovascular (heart or blood vessel) disease? Y / N

History of pulmonary (lung) disease or asthma? Y / N

History of diabetes? Y / N History of hypoglycemia? Y / N History of thyroid problems? Y / N

Have you ever had problems with extreme nervousness, anxiety or panic attacks? Y / N

Have you ever had any weight loss surgery (liposuction, gastric banding/stapling, intestinal bypass) Y / N

History of stomach or intestinal diseases or problems? Y / N

Have you ever taken/currently taking any of the following medications? (Circle all that apply):

Adipex Avelox	Avert	Balmamine	Bontril	Cafcit
Caffeine	Dexidrine	Mirapex	Diet pills	Effexor
Lamictal	Meridia	Zyprexa	Noroxin	Xenical
Ephedra	Ionamin	Tenuate	Vospire	
Phendimetrazine	Phenmetrazine	Phentermine		

7. Do you take Ritalin, Adderall or any other stimulant therapies? Y / N

Patient Signature: _____ Date: _____

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I _____, understand, respect, and agree to the following

TERMS AND CONDITIONS of this facility:

- Healthy Solutions Medical Weight Loss reserves the right to alter any fees for service at our discretion.
- No refunds or exchanges will be given for prepaid packages.
- Healthy Solutions Medical Weight Loss reserves the right to decline lab panel and EKG report information from another medical vendor.
- All information provided in this diet booklet is included with a patients initial visit fees. If a patient requires a supplementary diet booklet, a replacement copy can be provided at an additional cost.
- If a patient requests duplicates of medical information (EKG report, lab panel, progress reports, etc.) from Healthy Solutions Medical Weight Loss, the patient agrees to provide an endorsed 'Health Records Waiver'. A fee may be required prior to the receiving copies of the requested paperwork. The requested copies shall be furnished by the physician within fifteen (15) business days of the request.
- The patient understands that any unpaid balance shall be paid in full prior to receiving copies of requested medical information from Healthy Solutions Medical Weight Loss.
- The patient acknowledges there will be a fee for a returned check to Healthy Solutions for insufficient funds. If a second check is returned there will be a subsequent fee of \$30.00 or more. If this occurs, we will only continue to provide patient care on a cash only basis.

I have read and understood the above information, and agree to its terms and conditions.

(Patient Signature)

(Date)

(Parent or Guardian Signature, if patient is a minor)

(Date)

(Witness)

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By signing below, I consent to the use and disclosure of my health information to seek and receive payment for services given to me, and for the business operations of Healthy Solutions Medical Weight Loss. I understand that for use and disclosure of my health information for treatment purposes, the clinic will obtain my specific written authorization.

By signing below, I acknowledge that I have been provided a copy of the Healthy Solutions Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Healthy Solutions, and how I may obtain access to this information. I have been informed that Healthy Solutions staff will provide me with a fuller description of these rights upon my request.

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____ **Witness:** _____