CompleteClinics
Medical Wellness and Weight Loss

WELCOME

Date: _____ Birth date: _____ Age: _____

Name: _____(Single Married Divorced Other)
LAST FIRST MI *Please circle one*

Street Address: _____

City: _____State:_____ Zip:_____

What number would be best to leave an appointment reminder: (____)_____-_____
Cell phone: (____)_____-_____

Parent or Guardian Signature (if patient is a minor):_____

Occupation:_____E-mail:_____

Place of Employment:_____ Work #: (_____) _____-_____

Primary Doctor: _____Phone: (_____) _____-_____

Cardiologist (If applicable): _____Phone: (_____) _____-_____

Endocrinologist (If applicable):_____Phone: (_____) _____-_____

OBGYN (If applicable):_____ Phone: (_____) _____-_____

****May we contact your doctors to keep them updated on your progress in the program?**
_____YES _____NO

How did you hear about us? (Please check one) _____Patient/Doctor Referral _____Internet _____Radio/TV
_____Newspaper _____TV _____Billboard Ad

If Patient/Doctor Referral; Please give name: _____

Race/Ethnicity: _____ American Indian _____ Alaska Native _____ Asian
_____ Black or African American _____ Native Hawaiian
_____ Other Pacific Islander _____ White/Caucasian
_____ Declined to State

www.completeclinics.com / 877-547-6567

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE PHYSICIAN_____ TO RELEASE TO:
(Your Physician's Name)

( )	**1919 Midwest Road, Suite 100A, Oakbrook, IL 60523**	**Fax# (630) 214-0773**
( )	**1800 Nations Drive, Suite 112, Gurnee, IL 60031**	**Fax# (847) 782-9653**
( )	**3554 W. 95th Street, Evergreen Park, IL 60805**	**Fax# (630) 214-0773**
( )	**2266 N. Lincoln Avenue, 2nd Floor, Chicago IL 60614**	**Fax# (630) 214-0773**

_____ PATIENT MOST RECENT *BLOOD WORK* RESULTS AND *EKG*.

_____ PATIENT MOST RECENT *MAMMOGRAM* RESULTS.

PATIENT'S NAME: _____

PATIENT'S DOB: _____ PHYSICIAN'S CITY: _____

REQUESTING DOCTOR: Scott D. Morris, M.D.

PATIENT SIGNATURE: _____

DATE: _____

****Complete if you have had blood work done in the past 3 months*****

CONTROLLED MEDICATION INFORMATION AND CONSENT

ANORECTICES (PHENTERMINE, PHENDIMETRAZINE)

These are a class of medications which help to suppress the appetite and are generally associated with weight loss. These medications are indicated in the management of exogenous obesity as an adjunct in a regimen of weight reduction based on caloric restriction. These are medications that enhance weight loss by suppressing appetite and increasing metabolism. These medications are used as an aid to your weight loss.

DO NOT RELY ON THEM TOO HEAVILY!
YOU WILL NOT BE SUCCESSFUL IF YOU DO.

All of the medications that we use have been proven to be both safe and effective. We do prescribe appetite suppressants that are new to the market; however, their long-term effects are largely unknown. The class of medication, which suppresses the appetite through dopamine/nor epinephrine, has proven to be effective and limited side effects are predictable, manageable and reversible.

PHENTERMINE comes in various strengths and is dispensed as a tablet or capsule. There are both time-released and short acting formulations. The medication that is prescribed for you will take into account many different factors which the doctor will evaluate. Phentermine is slowly eliminated from the body, usually clearing the body within 4 to 5 days. Side effects include dryness of the mouth, agitation, headaches, irritability, heart palpitations and insomnia. Contraindications include untreated systemic hypertension, heart disease, glaucoma, bipolar depression, psychosis, hyperthyroidism, drug or alcohol abuse and pregnancy.

PHENDIMETRAZINE is dispensed as a multi-dose, 35 mg tablet. This medication is short acting and is usually eliminated from the body within 24 hours. Otherwise, it is essentially the same as Phentermine.

HUMAN CHORIONIC GONADOTROPIN (HCG) is a hormone that is secreted by the placenta during pregnancy. Studies have shown that it may be responsible for fat metabolization or increased fat loss, when used with the proper dietary protocols. While HCG is not approved for weight loss, federal laws do allow for physicians to use approve drugs "off-label". This is a common practice in medicine.

As with any medication, some people may experience side effects. The most common reported side effects in women were breast tenderness and changes in menses. Contraindications include a history of breast cancer, ovarian cancer, endometrial cancer and testicular cancer in men. Anyone with a past history of the conditions listed should not take HCG. **If you experience any problems with the medications or any other aspect of our program, please CALL OUR OFFICE.** We will be glad to assist you in any way that we can.

As a condition of treatment;

1. **I understand that HCG is not approved by the FDA for the treatment of Obesity.**
2. **I agree to follow all of the guidelines set and to take my medications as prescribed by Dr. Morris.**
3. **I have been informed of the possible side effects that may accompany my treatment with the medications.**
4. **I have reviewed the information pages and understand its uses, effects, side effects and contraindications for use. I understand this is an "off label" usage of these medications.**
5. **I understand that I may get my prescriptions filled at a pharmacy of my choice.**

I fully understand and agree to all conditions set forth in my treatment and agree to all of the above statements.

Patient Signature: _____ **Date:**_____

(Or Parent or legal guardian if a minor.)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Complete Clinics, Ltd. - Oakbrook, or Complete Clinics, Ltd. – Gurnee, or Complete Clinics, Ltd.- Arlington Heights, or Complete Clinics, Ltd. – North Barrington, Complete Clinics, Ltd. – Chicago (hereinafter collectively referred to as "Complete Clinics, Ltd.) to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

With this consent, Complete Clinics, Ltd., may call, mail, and e-mail to my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Any mailed items should be marked personal and confidential.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I have the right to request in writing that Complete Clinics, Ltd., restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting Complete Clinics, Ltd., use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Complete Clinics, Ltd., may decline to provide treatment to me.

CONSENT FOR CARE

I agree to treatment and intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____

Patient Signature: _____

Date: _____

COMPLETE IF PATIENT IS A MINOR CHILD. (Under the age of 18)

I,_____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care at Complete Clinics, Ltd.

_____ _____

Signature Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICAL HISTORY QUESTIONAIRE

Name: _____ **DOB:** _____ **DATE:** _____

A. Allergies to foods or medications: □ NONE

_____

B. Habits: Smoke? Y N How much? _____
Alcohol? Y N How much? _____

C. Family History

	Mother	Father	Other
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Hypertension	_____	_____	_____
Psychiatric Disorder	_____	_____	_____
Stroke	_____	_____	_____
Obesity	_____	_____	_____
Osteoporosis	_____	_____	_____

D. List all current medications: □ NONE

_____

_____

E. List all hospitalizations: □ NONE

_____

_____

F. List all surgeries: □ NONE

_____

_____

G. Chronic Illnesses: □ NONE

_____

_____

H. Alcoholism or drug problem? Y N
If yes, describe: _____

_____

Directions: Please circle Y (yes) or N (no) for each question. Answer all questions. If unsure, circle the truer one.

Respiratory System		
Shortness of breath (at rest)	Y	N
Night sweats	Y	N
Productive cough	Y	N
Bloody cough	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Emphysema	Y	N
Asthma	Y	N
Sleep apnea	Y	N

Cardiovascular		
Chest pain	Y	N
Hypertension	Y	N
Heart attack	Y	N
Heart failure	Y	N
Heart murmur	Y	N
Mitral valve prolapse	Y	N
Palpitations (racing heart beat)	Y	N
Peripheral vascular disease	Y	N
Edema (swelling of hands/feet)	Y	N

Gastrointestinal		
Abdominal pain	Y	N
Heartburn	Y	N
Ulcer	Y	N
Acid reflux	Y	N
Vomiting/Nausea	Y	N
Excessive pain	Y	N
Rectal bleeding	Y	N
Colitis	Y	N
Gallstones	Y	N
Constipation	Y	N
Diarrhea	Y	N

Psychological		
Depression	Y	N
Bipolar depressive illness	Y	N
Schizophrenia	Y	N
Anxiety/Panic Disorder	Y	N
Panic attacks	Y	N

Neurological		
Headaches	Y	N
Dizziness	Y	N
Numbness	Y	N
Epilepsy	Y	N
Seizure disorder	Y	N
Fainting	Y	N

Genitourinary		
Enlarged prostate	Y	N
Frequent night time urination	Y	N
Blood in urine	Y	N
Burning upon urination	Y	N

Ears, Eyes, Nose, & Throat		
Seasonal allergies	Y	N
Hearing loss	Y	N
Glaucoma	Y	N
Cataracts	Y	N

Endocrine		
High thyroid (hyper)	Y	N
Low thyroid (hypo)	Y	N
Diabetes	Y	N
Low blood sugar	Y	N
Gout	Y	N

Bones, Joints, Muscles		
Aching muscles/joints	Y	N
Low back pain	Y	N
Muscle cramps	Y	N
Osteoporosis	Y	N
Arthritis	Y	N

Other		
Cancer	Y	N
Anemia	Y	N
Fatigue	Y	N
Hot/Cold spells	Y	N
High cholesterol	Y	N

WOMEN
(Please answer the following)

Last menses (period): _____

Any pregnancies:	Y	N
Are you pregnant now?	Y	N
Are you breast feeding?	Y	N
Are you post menopausal?	Y	N
Abnormal female bleeding?	Y	N
Are you up- to-date on Pap smear?	Y	N
Mammogram?	Y	N

Birth control methods? (circle one)

Tubal Essure Diaphragm IUD Pills Rhythm

Condoms Depo-Provera Vasectomy

_____

WEIGHT HISTORY

1. I have tried to lose weight _____times in the last 5 years.

2. I have tried:
   _____Jenny Craig _____Weight Watchers
   _____Nutrisystem _____First Place
   _____Healthy Weigh _____Inches-A-Weigh
   _____Other_____

3. I lost: _____lbs.
   _____didn't lose any.
   _____gained back what I lost.

4. These medications have helped me lose weight in the past.
   _____Phentermine (Fastin, Ionimin, Adipex)
   _____Diethylpropion (Tenuate)
   _____Phendimetrazine (Melfiat, Bontril)
   _____Pondimin
   _____Redux
   _____Didrex
   _____"Phen-Fen"

5. The medications that I took:
   _____Gave me no side effects.
   _____Made me ill, and I had to stop.

Please answer each question as honestly as you can. If you do have a problem with compulsivity, it will be easier for you to lose weight if you are also treated for this condition. The doctor will discuss this with you during your consultation.

_____

1. Do you binge every week?	Y	N
2. Are you concerned with your body image?	Y	N
3. Do you induce vomiting when you overeat?	Y	N
4. Do you use laxatives or diuretics?	Y	N
5. Do you have an obsession with food?	Y	N

If you answered Y (yes) to 3 or more of these questions, it is possible that you may have a compulsive eating problem, or are well on the way to having one.

Additional Comments and Thoughts

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that it is my responsibility to notify the physician of any problems I may have with my program or medications. I will notify my physician if my family doctor prescribes any medications or treats any illness which has not been previously reported to this clinic.
I acknowledge that I have read and understand the above and will assume full responsibility for relating my medications to this clinic and my family doctor.

_____ _____

Patient Signature Date

COMPLETE CLINICS, LTD.

PATIENT FINANCIAL AND CANCELLATION POLICY

***Simeon's Protocol hCG Weight Loss Program*:** A patient must pay an upfront total of **$695.00 (40 day) or $595.00 (23 day)** for the HCG Weight Loss Diet Plan & Protocol, which includes restricted diet protocol, 40 day or 23 day supply of HCG injections taken daily for 40 days or 23 days, 3 or 2 follow up visits and one set of labs. ***

3-Month Weight Loss Program w/Medication & B12 Methyl Injections:

A patient must pay an upfront total of **$295.00** which includes the 3-Month Weight Loss program, 1st month of prescription appetite suppressants, 1st month of B12 Methyl injections @ 1x/week, one set of labs. Cost for month 2 & 3 is $75.00 per month (includes 30-day supply of prescription appetite suppressants, B12 Methyl injections @ 1x/week for 4 weeks).*******

3-Month Weight Loss Program w/Medication, B12 Methyl Injections & hCG Injections:

A patient must pay an upfront total of **$395.00** which includes the 3-Month Weight Loss program, 1st month of prescription appetite suppressants, 1st month of hCG injections @ 3x/week, 1st month of B12 Methyl injections @ 1x/week, one set of labs. Cost for month 2 & 3 is $175.00 per month (includes 30-day supply of prescription appetite suppressants, B12 Methyl injections @ 1x/week for 4 weeks & hCG injections @ 3x/week for 4 weeks).*******

6-Month Weight Loss Program w/Medication: A patient must pay an upfront total of **$450.00** for the 6-month Weight Loss Program1 which includes the 6-month Weight Loss program, 1st month of prescription appetite suppressants, 1st month of B12 Methyl injections @ 1x/wk, one set of labs. Cost per months 2-6, $75.00 (includes 30-day supply of prescription appetite suppressants, B12 Methyl injections @ 1x/wk for 4 weeks).*******

6-Month Weight Loss Program w/Medication & HCG: A patient must pay an upfront total of **$550.00** for the 6-month Weight Loss Program which includes the 6-month Weight Loss program, 1st month of prescription appetite suppressants, 1st month of hCG injections at 3x/wk, 1st month of B12 Methyl injections @ 1x/wk, one set of labs. Cost per months 2-6, $175.00 (includes 30-day supply of prescription appetite suppressants, B12 Methyl injections @ 1x/wk for 4 weeks & hCG injections @ 3x/wk for 4 weeks).*******

*******Additional supplements and other services are available at an additional cost and are not included in the upfront fee.
*******Increased dosage in prescription appetite suppressants will result in $25.00 additional cost on either Traditional Weight Loss program.
*******2nd Set of Labs is required at month 3 for the 3-month program and month 4 for the 6-month program at a cost of $30.00.
*******If not medically qualified for or not using prescription appetite suppressants on the Traditional program, a clinic credit will be issued onto your account.
*****GenetoSLIM** test is available for any of the above programs at an additional cost of $200.00.
*****Food Allergy Testing** is available for any of the above programs at an additional cost of $320.00.
*** Cost of medications and/or injections are subject to change without notice.

Broken/Missed Appointment or Late Cancellation*:** We reserve your appointment time for you. $25.00 deposit is required to secure your appointment time. If you are unable to keep your appointment, please call us 24 hours in advance to reschedule and to avoid being charged. ***THERE IS A LATE CANCELLATION FEE OF $25.00 IF LESS THAN 24 HOURS NOTICE IS GIVEN.

Refund Policy: Refund for Either 3-Month or 6-Month Weight Loss Programs: **A patient who enrolls in the 3-month weight loss program or GenetoSlim Test is not entitled to a refund for any reason whatsoever**. A patient who enrolls in either of the 6-month prepaid weight loss programs is not entitled to any refund for any reason, unless they have a valid medical reason for disenrollment from the program. If a medical reason were to occur, the patient must provide a doctor's diagnosis indicating the need for disenrollment. If such a diagnosis is provided, and it is deemed credible and accurate, Complete Clinics will provide a refund as follows: (1) After 1st Month: $70 (2) After 2nd Month: $50. Refunds may only apply to a 6-month program that has been paid in full upfront**. No refunds available for the 40-day or 23-day HCG Weight Loss program.**

A Nonrefundable Initial Consultation fee of $150.00 will apply if the patient elects not to pursue the 3-month, 6-month or Simeon's Protocol HCG Weight Loss program. If a patient elects not to pursue a weight loss program, but decides within 30 days of the Initial Consultation that they wish to continue the a weight loss program, the $150.00 Nonrefundable fee will be applied to the cost of the program of choice. The Initial Consultation visit will still be deemed the 1st of the 3/6 visits in the 3/6-month program (leaving 2/5 additional visits for the entire cost of the 3/6 month program).

By initialing below, I hereby acknowledge that I understand the financial agreement with Complete Clinics and will pay the program cost and cancellation fees deemed necessary. (Cancellation fee will apply if I do not provide the requisite 24 hours notice for any appointment).

Patient Initials _____

Visa, MasterCard, American Express, Discover, Debit Card, *Care Credit Account or Cash accepted as payment. Sorry, No Personal Checks are Accepted!

*Additional fees will apply when using your Care Credit Account

COMPLETE CLINICS, LTD

PHOTOGRAPHIC RELEASE AND CONSENT

I, _____ agree that a Health Care Practitioner of Complete Clinics, Ltd., or designated representatives or the practice may take and use pre and post procedures photographs of my person for confidential clinical record purposes and that such photographs shall remain the property of Complete Clinics, Ltd.

I **DO / DO NOT** give my permission for Complete Clinics, Ltd. to disclose my weight loss, and CVAC accomplishments on their Website Blog, Twitter or Facebook page either using my (check all that apply), _____Real First Name, Last Initial **and/or** _____Abbreviated Name. Complete Clinics, Ltd., will not post any inaccurate or false information about my accomplishments.

_____ _____

Patient Signature Date

For below purposes, I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Complete Clinics, Ltd., to use my photographs, videotapes, and case information in the following educations and scientific settings that I have initialed:

_____ Complete Clinics office patient education materials.

_____ Complete Clinics file pre and post procedure patient photographs available to prospective patients for viewing in the office.

_____ Newspaper and magazine articles in which Complete Clinics, Ltd. participates.

_____ Television programs in which Complete Clinics, Ltd. participates.

_____ Complete Clinics, Ltd. personal web site or web page.

_____ Lectures and multimedia presentations given by Complete Clinics, Ltd. for the general public.

I also authorize Complete Clinics, Ltd. Health Care Practitioner's professional associations to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

_____ Patient education brochures available for purchase.

_____ Educational video tapes available for purchase.

_____ Lectures and slide presentations available for purchase.

_____ Television programs about weight loss and aesthetic enhancement.

_____ Case studies presented on the website at www.completeclinics.com

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

_____

Signature of Practice Representative and Witness

06/12