Attention all new patients and all existing patients:

Please be aware according to FL Statutes. We must do re-evaluations at least every 3 months to stay compliant by the following guidelines mandated by the state of Florida.

64B8-9.012 Standards for the Prescription of Obesity Drugs.
The prescription of medication for the purpose of enhancing weight loss should only be performed by physicians qualified by training and experience to treat obesity. All licensees are expected to abide by the following guidelines and standards in the utilization of any drug, any synthetic compound, any nutritional supplement, or herbal treatment, for the purpose of providing medically assisted weight loss.

(1) To justify the use of weight loss enhancers as set forth above, the patient must have a Body Mass Index (BMI) of 30 or above, or a BMI of greater than 27 with at least one comorbidity factor, or a measurable body fat content equal to or greater than 25% of total body weight for male patients or 30% of total body weight for women. The prescription of such weight loss enhancers is not generally appropriate for children. Any time such prescriptions are made for children, the prescribing physician must obtain a written informed consent from the parent or legal guardian of the minor patient in addition to complying with the other guidelines and standards set forth in this rule. BMI is calculated by use of the formula BMI = kg/m².

(2) Physicians in Florida are prohibited from prescribing, ordering, dispensing, or administering any weight loss enhancer that is both a serotonergic and anorexic agent unless the drug has been approved by the Food and Drug Administration (FDA) specifically for use in weight loss management. Selective serotonin re-uptake inhibitors (SSRIs) that have not been approved by the FDA for weight loss may not be prescribed, ordered, dispensed, or administered for such purposes.

(3) An initial evaluation of the patient shall be conducted prior to the prescribing, ordering, dispensing, or administering of any drug, synthetic compound, nutritional supplement or herbal treatment and such evaluation shall include an appropriate physical and complete history; appropriate tests related to medical treatment for weight loss; and appropriate medical referrals as indicated by the physical, history, and testing; all in accordance with general medical standards of care.

(a) The initial evaluation may be delegated to an appropriately educated and trained physician's assistant licensed pursuant to Chapter 458, F.S., or an appropriately educated and trained advanced registered nurse practitioner licensed pursuant to Chapter 464, F.S.

(b) The initial evaluation required above is delegated to a physician's assistant or to an advanced registered nurse practitioner, then the delegating physician must personally review the resulting medical records prior to the issuance of an initial prescription, order, or dosage.

(4) Prescriptions or orders for any drug, synthetic compound, nutritional supplement or herbal treatment for the purpose of assisting in weight loss must be in writing and signed by the prescribing physician. Initial prescriptions or orders of this type shall not be called into a pharmacy by the physician or by an agent of the physician. Even if the physician is registered as a dispensing physician, a hard copy of the written prescription must be maintained in the patient's medical records for each time such weight loss enhancers are prescribed, ordered, dispensed, or administered.

(5) At the time of delivering the initial prescription or providing the initial supply of such drugs to a patient, the prescribing physician must personally meet with the patient and personally obtain an appropriate written informed consent from the patient. Such consent must state that there is a lack of scientific data regarding the potential danger of long term use of combination weight loss treatments and shall discuss potential benefits versus potential risks of weight loss treatments. The written consent must also clearly state the need for dietary intervention and physical exercise as a part of any weight loss regimen. A copy of the signed informed consent shall be included in the patient's permanent medical record.

(6) Each physician who is prescribing, ordering, or providing weight loss enhancers to patients must assure that such patients undergo an in-person re-evaluation within 2 to 4 weeks of receiving a prescription, order, or dosage. The re-evaluation shall include the elements of the initial evaluation and an assessment of the medical effects of the treatment being provided. Any patient that continues on a drug, synthetic compound, nutritional supplement or herbal treatment assisted weight loss program shall be re-evaluated at least once every 3 months.

(7) Each physician who prescribes, orders, dispenses, or administers any drug, synthetic compound, nutritional supplement or herbal treatment for the purpose of assisting a patient in weight loss shall maintain medical records in compliance with Rule 64B8-9.003, F.A.C., and must also reflect compliance with all requirements of this rule.

(8) Each physician who prescribes, orders, dispenses, or administers weight loss enhancers for the purpose of providing medically assisted weight loss shall provide to each patient a legible copy of the Weight-Loss Consumer Bill of Rights as set forth in Sections 501.0575(1)(a) through (c)(3, F.S. The physician shall also conspicuously post said document in those rooms wherein patients are evaluated for weight losstreatment.

(9) Any physician who advertises practice relating to weight loss or whose services are advertised by another person or entity

---

Patient’s Signature  Date

3/22/18
PATIENT INFORMATION FORM

Patient Name: (Last)____________________(First)____________________(MI)________________
Name you prefer to be called: __________________________________________
Patient Address: __________________________________________
City: __________________________ State: __________ Zip: __________
Email Address: __________________________________________
Cellular Phone: __________________________ Home or Alternate Phone: __________________________
Date of Birth: __________________________ Age: _______ Sex: M    F
Social Security: __________________________ Driver’s License: __________________________

Employment Information:
Patient Employer: __________________________ Occupation: __________________________
Employer Address: __________________________________________
City: __________________________ State: __________ Zip: __________
Work Phone No: __________________________ Ext. __________________________

How Did You Hear About Us:
☐ Internet   ☐ Email   ☐ Location/Sign   ☐ Phonebook   ☐ Other (please specify)______________
☐ Doctor Referral (please specify who so we can send a Thank You)________________________
☐ Patient Referral (please specify who so we can send a Thank You)________________________

In Case of Emergency:
Name: __________________________ Relationship: _________ Phone: __________
Patient’s Spouse: __________________________ Phone: __________
Family Physician: __________________________ Phone: __________
FINANCIAL POLICY

Thank you for selecting Doctor Rx Weight Loss, L.L.C. for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express and Discover.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_________________________________________    __________________________
Patient’s Signature                        Date
MEDICAL HISTORY FORM

Name: ________________________________  Age: _______  Sex: M  F

Family Physician: ________________________________  Phone: __________________

Present Status:

1. Are you in good health at the present time to the best of your knowledge?   Yes  No

2. Are you under a doctor’s care at the present time?   Yes  No
   If yes, for what? __________________________

3. Are you taking any medications at the present time?   Yes  No
   What: ____________________________ Dosages: __________
   What: ____________________________ Dosages: __________

4. Any allergies to any medications?   Yes  No
   __________________________

5. History of High Blood Pressure?   Yes  No

6. History of Diabetes?
   At what age: __________
   Yes  No

7. History of Heart Attack or Chest Pain?   Yes  No

8. History of Swelling Feet?
   Yes  No

9. History of Frequent Headaches?
   Migraines? Yes  No
   Medications for Headaches: ______________________________________
   Yes  No
   __________________________

10. History of Constipation (difficulty in bowel movements)?   Yes  No

11. History of Glaucoma?   Yes  No

12. Gynecologic History:
   Pregnancy: Number: __________  Dates: _________________
   Natural Delivery or C-Section (specify): __________________________
   Menstrual: Onset: _______________
   Duration:_____________________
   Are they regular: Yes  No
   Pain associated: Yes  No
   Last menstrual period: __________________________
   Hormone Replacement Therapy:   Yes  No
   What: __________________________
   Birth Control Pills:   Yes  No
   Type: __________________________
   Last Check Up: __________________________

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13. Serious Injuries:  
Specify: ____________________________ Date: ____
Yes  No

14. Any Surgery:  
Specify: ____________________________ Date: ____
Specify: ____________________________ Date: ____
Yes  No

15. Family History:

<table>
<thead>
<tr>
<th>Father:</th>
<th>Age</th>
<th>Health</th>
<th>Disease</th>
<th>Cause of Death</th>
<th>Overweight</th>
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Has any blood relative ever had any of the following:

| Glaucoma: | Yes  No  Who: |     |
| Asthma:   | Yes  No  Who: |     |
| Epilepsy: | Yes  No  Who: |     |
| High Blood Pressure: | Yes  No  Who: |     |
| Kidney Disease: | Yes  No  Who: |     |
| Diabetes: | Yes  No  Who: |     |
| Tuberculosis: | Yes  No  Who: |     |
| Psychiatric Disorder: | Yes  No  Who: |     |
| Heart Disease/Stroke: | Yes  No  Who: |     |

Past Medical History: (check all that apply)

- Polio
- Jaundice
- Kidneys
- Lung Disease
- Rheumatic Fever
- Ulcers
- Anemia
- Tuberculosis
- Drug Abuse
- Pneumonia
- Cholera
- Arthritis
- Measles
- Mumps
- Scarlet Fever
- Whooping Cough
- Bleeding Disorder
- Gout
- Heart Valve Disorder
- Gallbladder Disorder
- Eating Disorder
- Malaria
- Cancer
- Osteoporosis
- Tonsillitis
- Pleurisy
- Liver Disease
- Chicken Pox
- Nervous Breakdown
- Thyroid Disease
- Heart Disease
- Psychiatric Illness
- Alcohol Abuse
- Typhoid Fever
- Blood Transfusion
- Other:
Nutrition Evaluation:

1. Present Weight: ________ Height (no shoes): ________ Desired Weight: ________
2. In what time frame would you like to be at your desired weight? ____________________________
3. Birth Weight: _____ Weight at 20 years of age: ________ Weight one year ago: ________
4. What is the main reason for your decision to lose weight? ____________________________
5. When did you begin gaining excess weight? (Give reasons, if known): ___________________
6. What has been your maximum lifetime weight (non-pregnant) and when? __________________
7. Previous diets you have followed: Give dates and results of your weight loss:
                                  ____________________________  ____________________________
                                  ____________________________  ____________________________
8. Is your spouse, fiancée or partner overweight? Yes No
9. If yes, by how much is he/she overweight? ____________________________
10. How often do you eat out? _____________________________________________
11. What restaurants do you frequent? ___________________________________________
12. How often do you eat “fast foods?” __________________________________________
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you shop for groceries? __________________________
16. Food allergies: _____________________________________________________________
17. Food dislikes: _______________________________________________________________
18. Food you crave: _____________________________________________________________
19. Any specific time of the day or month do you crave food? __________________________
20. Do you drink coffee or tea? Yes No How much daily? _____________________________
21. Do you drink cola drinks? Yes No How much daily? _____________________________
22. Do you drink alcohol? Yes No

23. Do you use a sugar substitute? ________ Butter? ________ Margarine? __________

24. Do you awaken hungry during the night? Yes No
   What do you do? ________________________________

25. What are your worst food habits? ________________________________

26. Snack Habits:
   ________________________ ________________________ __________

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:
   ________________________________
   ________________________________

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:
   ________________________________
   ________________________________

29. Smoking Habits: (answer only one)
   □ You have never smoked cigarettes, cigars or a pipe.
   □ You quit smoking _____ years ago and have not smoked since.
   □ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
   □ You smoke 20 cigarettes per day (1 pack).
   □ You smoke 30 cigarettes per day (1-1/2 packs).
   □ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast   Typical Lunch   Typical Dinner
   ________________________ ________________________ ________________________
   ________________________ ________________________ ________________________
   ________________________ ________________________ ________________________
   Time eaten: __________ Time eaten: __________ Time eaten: __________
   Where: __________ Where: __________ Where: __________
   With whom: __________ With whom: __________ With whom: __________

31. Describe your usual energy level: ________________________________
32. Activity Level: **(answer only one)**
   - Inactive – no regular physical activity with a sit-down job.
   - Light activity – no organized physical activity during leisure time.
   - Moderate activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
   - Heavy activity – consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
   - Vigorous activity – participation in extensive physical exercise for at least 60 minutes per session, 4 times per week.

33. Behavior style: **(answer only one)**
   - You are always calm and easygoing.
   - You are usually calm and easygoing.
   - You are sometimes calm with frequent impatience.
   - You are seldom calm and persistently driving for advancement.
   - You are never calm and have overwhelming ambition.
   - You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: __________________________

                               __________________________
                               __________________________
                               __________________________

35. Do you filter your drinking water?   Yes    No

36. Do you ionize your drinking water?   Yes    No

37. Do you have full spectrum lighting in your home/office?   Yes    No

38. Do you use your computer or mobile phone late in the evening?   Yes    No

39. Are you exposed to EMF’s at home or work (i.e. computers, cellphones, electronic devices, microwave, etc.)?   Yes    No

40. Do you get 6.5 to 8 hours of sleep per night?   Yes    No

41. Do you filter the air in your office or home?   Yes    No

42. Do you ionize the air in your office or home?   Yes    No

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.
PATIENT CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

I ____________________________ (patient or patient’s guardian) authorize Dr Ford of Doctor Rx Weight Loss, L.L.C. to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

1. I have read and understand my doctor’s statements that follow:

“Medication, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressants labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.”

“As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger does than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggest, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.”

“Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).”

“As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risk of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give.”

2. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

4. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange-eating program without the use of appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.
II. **Risk of Proposed Treatments:**
I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include; nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication, allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and vascular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. **Risk Associated with Being Overweight or Obese:**
I am aware there are certain risk associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and no arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. **No Guarantees:**
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 I will have to continue watching my weight all my life if I am to be successful.

V. **Patient’s Consent:**
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, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

**WARNING**
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTION WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: ____________________________________ TIME: __________________________

PATIENT: __________________________________ WITNESS: ______________________
(or person with authority to consent for patient)

VI. **Physician Declaration:**
I have explained the contents of this document to the patient and have answered all the patient’s related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician’s Signature ________________________________
WEIGHT LOSS PROGRAM POLICY

I understand that if I develop any side effects from the Doctor Rx Weight Loss, L.L.C program, I will stop the diet and/or medication and notify the doctor at Doctor Rx immediately. If the problem is severe, I will go to the Emergency Room immediately.

There is no guarantee the program will work for me you. By signing below, you certify you have read and fully understand this consent form. You should not sign this form if you have any questions or concerns that have not been answered to your complete satisfaction. Your signature further confirms that you do not have a history of alcohol abuse, drug abuse, schizophrenia, or manic-depressive illness or a history of any eating disorder since these conditions are a contradiction to the use of appetite suppressants. You agree not to take any other appetite suppressants, other medications or injections other than those prescribed by the Doctor Rx doctor or listed and approved on your medical history form. You will inform the doctor of any change in your medication.

I understand that the Doctor Rx Weight Loss program, all written materials describing the program or any of its parts, applicable trademarks, copyrights and other intellectual property in or our program are and remain our absolute property. You acknowledge that you are purchasing a non-exclusive, non-transferable license to use our program and the related written materials for your own use, and that you have no right to duplicate or to sell, lend or transfer in any way to any other person the use of our program or written materials.

Again, thank you for selecting Doctor Rx Weight Loss for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, checks and cash. You understand that our services are not reimbursed by insurance, and we do not provide or fill out claim forms for insurance. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees and court costs. You also understand that no refunds will be given at any time for any reason. I have read and understand all of the above and have agreed to these statements.

________________________    _____________________
Patient        Date

________________________
Witness

3/22/18
NOTICE OF PRIVACY PRACTICES FOR PROTECTED
HEALTH INFORMATION

“This Notice Describes How Medical Information About You May Be Used And Disclosed
And How You May Get Access To This Information.” Please Review It Carefully.

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer.
Charts are stored in a secure area and available only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of the computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and billing personnel. We may use your medical information for treatment and care, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses), billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, products recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provide authorization is IRB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Worker’s compensation
- Disaster relief and fundraising

We will not use or disclose your medical information for any purpose not listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
PATIENT PRIVACY RIGHTS

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your information to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of the notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can complain about our privacy policy or its execution either verbally or in writing to our office. If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services. Effective Date: April 14, 20003

PRIVACY NOTICE RECEIPT

I have read and/or requested a copy of Doctor Rx Weight Loss privacy notice as required by HIPPA.

Signature: _______________________________ Date: __________________

Patient’s Printed Name: ___________________________________________

Witness: _______________________________ Date: ___________________
RELEASE OF MEDICAL RECORDS

I give permission for my medical records (blood work, chart, EKG) to be released to:

DOCTOR RX WEIGHT LOSS, L.L.C
2828 SOUTH TAMIAMI TRAIL
SARASOTA, FL 34239
PHONE (941) 957-0200
FAX (941) 953-7883

Printed Name ________________________________

Signature _________________________________

Date _________________________________
WEIGHT-LOSS CONSUMER BILL OF RIGHTS

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

__________________________________________________________  ________________________________
Patient’s Signature                                               Date
WEIGHT LOSS PROGRAM CONSENT FORM

I _______________________________ authorize Dr. Robert E. Ford & Doctor Rx weight Loss, L.L.C 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, 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 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 concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _______________________________ Time: _______________________________
Witness: ___________________________ Patient: ____________________________
(Or person with authority to consent for patient)
CONFIDENTIALITY AGREEMENT

The undersigned reader acknowledges that the information provided herein pertaining to Doctor Rx Weight Loss, LLC in this business plan is confidential; therefore reader agrees not to disclose it without the express written permission of Doctor Rx Weight Loss, LLC.

It is acknowledged by reader that the information to be furnished in this business plan is in all respects confidential in nature, other than information which is the public domain through other means and that any disclosure or use of same by reader, may cause serious harm or damage to Doctor Rx Weight Loss, LLC.

Upon request, this document is to be immediately returned to Doctor Rx Weight Loss, LLC.

_______________________    ________________________
Signature      Witness
PATIENT CONTACT INFORMATION

On occasion, we will contact you regarding your weight loss program and ongoing promotions. To better serve you, please provide us with your email address and cell phone number.

Cell Phone:___________________________________

Email:__________________________________________

Patient Name (Print):_____________________________________

Patient Signature:________________________________________

Date:_________________________

Witness:_________________________