Patient Registration and Information Form

Patient's Last Name: _____ First Name: _____ M.I._____

DOB: _____ Social Security# (***required***): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____Wireless Provider (***text reminders***): _____

Email: _____

Emergency Contact:_____ Phone #:_____

Referred to clinic by/ Chose clinic because:

Medical History

Please list all medications/supplements currently taking:

_____

_____

_____

Allergies:

_____

List of Current Medical Conditions:

_____

_____

_____

Have you had an EKG in the past?_____

Circle any history of the following:

Heart disease Heart Attack Heart Stent Heart Surgery Glaucoma Seizures Diabetes Kidney Stones Thyroid Cancer

FINANCIAL POLICY

All services require payment prior to actual services being done.
NO REFUNDS GIVEN

Insure you have correctly the prescreen to avoid paying for this service that you DO NOT qualify for.

Forms of payment accepted:

Cash, Credit, or Debit

NO CHECKS
NO HEALTH SAVNGS ACCOUNT
NO FLEXIBLE SPENDNG ACCOUNT

Body Rx and Dr. Nair. enforce a 24-bour cancellation policy for **ALL** appointments. In order to reschedule your appointment, you must notify Body Rx at (502)882-8680 or (502)974-3447 24 hours before your scheduled appointment time to avoid being charged a **$50 cancellation/no show fee**.
You will be dismissed from the program if there are three no shows on your account.

With our Weight Management Program, Dr. Nair does allow a 2-month grace period between appointments.

If you are not back to see the provider within two months from your previous visit, the program does start back over and you will be charged the initial visit fee of $135 again.

The program works best when seeing your provider as close to once a month as possible. Please try to abide by this timeline.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Patient Informed Consent for Weight Loss Program

Procedure and Alternatives

I, _____ , authorize Dr. Nair, and his team, to assist me in my weight reduction efforts. I understand my treatment may involve, but is not limited to, the use of appetite suppressants and other medications as needed for more than 12 weeks.

I understand it is my responsibility to follow the instructions carefully and report any significant medical problems that I think may relate, to the doctor treating me as soon as possible. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain the weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that much of my success in 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 of my life if I am to be successful.

Patient Consent

I have read and fully understand this consent form. I realize that I should not sign this form if all items have not been explained, or if any questions concerning the program 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 as well as all other treatments in this program not involving the appetite suppressants. I understand that if I have Glaucoma, I am unable to participate in the weight loss program due to contradictions in the medications.

Patient Signature: _____ Date: _____

Narcotic Consent Form

I _____, agree to all terms below:

All controlled substances will be obtained from:

Pharmacy Name: _____ **Date**: _____

1. I will not seek pain medicine/narcotics from another doctor/provider.
2. I will adhere to dosing instructions as prescribed, will not self-increase, and realize the potential risk of dependency.
3. I will not give or sell my pain medicine/narcotics to anyone.
4. I will not receive pain medicine/narcotics from anyone.
5. I will be responsible and keep pain medicine/narcotics safe at all times.
6. In the event of lost, stolen, or any mishaps I will not request replacement of pain medicine/narcotics.
7. If I have become dependent on pain medicine/narcotics or possess even a small risk of addiction, I will see an addiction specialist if my doctor deems necessary.
8. I will be compliant with blood/urine test for drug monitoring when asked by my provider or when randomly selected.
9. I will avoid the use of any mood-altering substance, such as tranquilizers, sleeping pills, alcohol, or illicit drugs (such as cannabis, cocaine, heroin, or hallucinogens.)
10. I will exercise complete honesty with my doctor and any other health care providers involved in my controlled substance, such as pharmacists, emergency departments, etc., in reporting all pain medications/narcotics.
11. I understand I may be called in for a random pill count, failure to come in for count could be grounds for dismissal.
12. We will check the state pharmacy board periodically to ensure that you are not obtaining controlled prescriptions from other providers or using multiple pharmacies.
13. Failure to adhere to this agreement could jeopardize my doctor/patient relationship thus stopping the prescribing of narcotic medications and may even result in dismissal from the practice.

Patient Name (Print): _____ **Patient Signature:** _____

BodyRx Louisville's Monthly Weight Loss Competition

Each month, we will be keeping track of each patient's weight loss.

While keeping track of each patient's weight loss progression, we will be tracking those who fall into the top five spots who lose the most weight for the month.

To whom loses the most weight and holds the 1st place spot, will receive a free ultra-burn injection!

If you choose to participate in this competition, please sign and date to give your consent for BodyRx Louisville to allow your initials or the name of your choice to be written on our competition chalkboard.

If you choose to not participate, then leave this document blank.

Name: _____Date:_____

Ultraburn Injection Consent

I understand and acknowledge:

- This injection contains methionine, inositol, choline chloride, & cyanocobalamin
- This injection does contain sulfur, if I have a sulfur allergy I should not take it
- It is my responsibility to inform the provider if I have a sulfur allergy
- I am a legal adult over the age of 18 and fully competent to make my own health care decisions
- I have read and understand this consent form, all of my questions have been answered
- I acknowledge that once the ultra-burn injection leaves BodyRx Louisville it cannot be returned for any reason, including asking BodyRx Louisville staff to administer the injection
- The injection should be kept at room temperature, away from children
- Give the injection in a sterile environment

Signature: _____Date: _____

- In the past 3 months, did you have any episodes of excessive overeating? (more than what most would eat in the same time period)? YES / NO
- Do you feel distressed about episodes of excessive overeating? YES / NO

If you answered no to the following questions, disregard the questions below.

Within the past 3 months…	Never or Rarely	Sometimes	Often	Always
During your episodes of excessive overeating, how often did you feel like you had no control over your eating? (not being able to stop or going back and forth for more food)				
During your episodes of excessive overeating, how often did you continue eating though you were not hungry?				
During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

Do you know what we have to offer at our medical spa?

Please circle anything that interests you; we would love to tell you more about it!

bodyrxlouisville.com

Body Treatments
Massage
Back Treatment

Skin Care Product
Glo Therapeutics
Glo Minerals

Facial Treatments
Lash & Brow Tinting
Chemical Peels
Customized Facials
Laser Facial
Microblading

Injectables
Botox
Dermal Fillers
PDO Threading

Vein Treatments
Laser Vein Removal
Sclerotherapy

Hair Removal
Waxing
Threading
Laser Hair Removal

Weight Management
Medical Weight Loss Program
HCG
Ultra-Burn Lip Injections

Do you have any skin concerns? **Yes** or **No**
How would you like for us to contact you? **Text**____ **Call**____ **Email**____
Free Consultation? **Yes** or **No**

Client Name: _____

Date: _____

Client Signature: _____

HIPAA Notice of Privacy Practices

BodyRx Louisville

8594 Dixie Highway Louisville KY, 40258

502.882.8680

BodyRx Louisville

601 South Hurstbourne Parkway

Louisville KY, 40222

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintain the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice property. We are required by law maintain the privacy of protect health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

This medical practice collects health information about you and stores it in a chart and in an electronic personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical records belong to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick, injured, or after you die.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with our "business associates," such as our billing services, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with our healthcare providers, healthcare clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce healthcare costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.