HEALTHY SOLUTIONS MEDICAL weight loss & spa

Bert Morales, M.D.

2003 Miccosukee Rd.
Tallahassee, FL. 32308
(850) 309-0356

Please be advised that completing this preliminary health questionnaire does not establish a physician-patient relationship with this practice.

Dr. Morales and his medical staff will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

PATIENT INFORMATON: (PLEASE PRINT)

Name: _____ DOB: _____

Age: _____ Sex: _____

Address: _____

City/State: Zip: _____

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

Email: _____

**I would like to receive email specials, recipes, and updates yes____ No____

Pharmacy: _____Phone:_____

Primary Care Doctor: _____ 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? _____

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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 any medications, herbal therapies, non-prescriptions drugs, etc: **Y / N**
If yes, list: _____

Do you have allergies to any medications? **Y / N** If yes, 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 a 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:

1. **PAYMENT IN FULL** is expected at the time of your visit. We accept cash, check or credit card (Visa, MasterCard and Discover). On your first visit, we will ask for a copy of an ID card or Driver's License due to the many cases of identity theft and required for prescription reporting.

2. **RETURNED CHECKS** will incur a $30.00 service charge. Credit card, cash, certified funds or a money order may be used to cover the amount of the check plus the $30.00 service charge. The balance must be paid prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted.

3. **NO SHOW APPOINTMENTS**: Please be respectful of your appointment time. If you do not cancel/reschedule your appointment, **you are subject to a $25.00 no show fee**.

4. **FORMS FEES**: Completing insurance medical need forms or letters, copying medical records, faxing documents, etc. requires office staff time away from patient care. We require pre-payment for completing forms, copying medical records, notarizing, and mailing. Base form charges are $10 per occurrence. Copying fees for medical records is$10 for the first twenty (20)pages and $0.50 per page in excess of twenty. Please allow 5 business days for our staff to fulfill your request, and these 5 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

5. Healthy Solutions Medical Weight Loss reserves the right to alter any fees for service at our discretion.

6. Healthy Solutions Medical Weight Loss reserves the right to decline lab panel and EKG report information from another vendor.

7. 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.

8. **COLLECTION FEES**: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes, but is not limited to, late fees, collections agency fees, court costs, interest and fines. I understand that these fees will be my personal responsibility to pay in full.

I HAVE READ AND UNDERSTAND HEALTHY SOLUTIONS' NOTICE OF PRIVACY PRACTICES AND THE TERMS AND CONDITIONS. I AGREE TO BE BOUND BY ITS TERMS. AT MY REQUEST, I WILL RECIEVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient or patient representative **Date**

_____

Printed name of patient