LOOK YOUNG
ATLANTA

New Patient Information

Last Name_____ First Name_____ M.I. _____
Birth Date_____
Mailing
Address _____
City_____ State _____ Zip _____
E Mail Address _____
Home Phone_____(May we leave a message at this number? Y/N)
Alt Phone_____(May we leave a message at this number? Y/N)
How did you hear about us?_____

Health Information

Primary Health concerns _____

Any Known Health problems_____

Past Hospitalizations _____

Past Surgeries _____

Current Medications_____

Current Supplements/vitamins _____

Allergies (foods/drugs/environmental) _____

Exercise (type/hours per week) _____

Do you smoke? Yes / No Packs/day_____ How many years of smoking? _____

Do you drink Caffeine? Yes / No

Nutrition / Diet

Do you follow a particular diet? Have you gained/lost weight recently? Describe:

What are the names of weight loss programs or diets that you have tried?

Which type of diet was the most successful for you?

Please list foods you eat regularly for:

Breakfast

Lunch

Dinner

Amount of weight you would like to lose on the HCG Program_____

Please check all that apply:

	Past	Present		Past	Present
Fatigue			Neck/ shoulder pain		
Fever			Leg pain		
Night Sweats			Spasms/ crams		
Insomnia			Tendonitis		
Hot Flashes			Numbness/ tingling		
Rash/ skin problems			Sciatica/ shooting pain		
Arthritis/ stiff/ painful			Heat disease		
Osteoporosis			Stroke		
Bladder/ Kidney problems			Blood clots		
Cancer			High blood pressure		
Gas/ Bloating			Chest pain		
Abdominal Pain			Shortness of breath		
Constipation/ Diarrhea			Asthma/ Allergies/ Hay fever		
Thyroid dysfunction			Dizziness		
Diabetes			Infection		
Pregnancy			Disc problem		
PMS/ menstrual problems			Heart murmur		
TMJ or Jaw pain			Epilepsy/seizures		
Depression			Gout		
Anxiety					

Family History - major health problems (cancer, cardiovascular disease, obesity, diabetes, osteoporosis, Depression) Father_____

Mother_____

Siblings_____

_____I affirm that I have had blood tests within the past year and they were normal and did not indicate any health problems.

_____I affirm that I have had a health exam within the past year and that I have no known health problems, other than what I have listed above.

By signing below I state that I have fully read over and filled out the above health history questionnaire truthfully and accurately.

Signature_____Date_____

Consent for Medical Weight Loss

I,_____, consent for treatment with Dr. John Ouderkirk for weight loss. I understand that Dr. John Ouderkirk practices holistic, anti-aging, and integrative medicine. The treatments recommended are safe and effective but may deviate from therapies that are considered to be standard for care in traditional medicine. I have an interest in using non-pharmaceutical treatments and prefer a more natural approach, whenever possible. The treatments offered by Dr. Ouderkirk are progressive and alternative. He has used them safely and successfully for many patients but with any medical treatment, there can be side effects and adverse results. Each of us are biochemically unique and may react unexpectedly to therapies. I will not hold Dr. Ouderkirk or his staff responsible if I have an unexpected or adverse reaction to treatment. I will call the office and inform Dr. Ouderkirk's staff of side effects in order for him to make recommendations to modify my treatment plan. It is Dr. Ouderkirk's intention to help me obtain optimal wellness and weight loss. He bases his recommendations on my clinical response as well as laboratory test results, if they are so given. It is expected that I will have frequent follow-up visits and communication with Dr. Ouderkirk and/or his staff. When the office calls me for follow-up appointments, I will comply and set up my follow-up appointment, which may be as frequent as every week during the diet program. This follow-up is necessary for my own safety. Refills of hormone prescriptions will not be made if I do not call or come in for monitoring and follow-up.

General and Injection Risks

I understand, and am completely satisfied, that the general risks of this proposed treatment and therapy include, but are not limited to, bruising, soreness or pain and possible swelling, allergic reaction or infection at the injection site.

Patient Compliance--Informed Consent Agreement

I appreciate, understand and agree to follow the proposed treatment and therapy as prescribed without any deviation, including the fact that I may be responsible for injecting, or taking by mouth, the hormones or other designated therapies that may be prescribed to me, possibly more than once.

I also agree to take the dietary supplements, hormone preparations and other designated therapies on the schedule that has been individually created for me, as prescribed specifically in detail. I have completely and faithfully disclosed my complete medical history, all prescription and non-prescription medications that I am currently taking or plan to take during my treatment. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from you, before stopping any of the prescribed therapeutic regimens or taking any additional preparations that are not suggested or prescribed by you. I also understand that the use of "social substances" such as tobacco, "street drugs" and alcohol and other types of otherwise thus non-described "social substances" may affect my therapy in a significantly adverse manner.

Other Medical Conditions

I will now certify that I am under the care of another physician for all other medical conditions. I will consult this physician for any other medical services whether it is classified as emergency or non-emergency personal health crises.

The meaning of "off-label" use

Medical weight loss is a therapy with off-label use of medications. In the United States, the regulations of the Food and Drug Administration (FDA) permit physicians to prescribe or use approved medications for other than their intended indications. The practice is known as "off-label use" or "unlabeled uses". Such uses are not indicative of inappropriate usage and are common. This means that the substances used are labeled for other conditions or uses than the current clinical use being prescribed. To access more information on "off-label use", please see the FDA's website: www.fda.gov/cder

I now authorize Dr. John Ouderkirk to begin my treatment and release Dr. Ouderkirk and staff of any liabilities whatsoever, including legal fees, or legal or medical liabilities that may result from the therapy.

Patient Signature: _____ Date: _____

CANCELLATION POLICY

I understand all monies paid for services rendered (packages or individual), are **non--refundable.** All rules and regulations of Look Young Atlanta shall be binding between the patient, Dr. Ouderkirk and relevant parties concerned.

I, _____agree with the terms of the above mentioned policy.

_____ _____
Client Signature Date

RELEASE OF LIABILITY

Services are performed solely at your own risk. Neither Dr. John Ouderkirk, Look Young Atlanta, or any employee or employees or its/his affiliates are responsible for damages caused to you during treatments received or performed.

I _____accept all liability for all treatments performed, sold, or provided. I understand that all services are performed solely at my own risk. I declare under penalty of perjury, under the laws of the United States of America and the State of Georgia, that I am being treated at my own request and my own risk, and that all information on all forms are true and correct.

Signature _____ Date _____

Authorization for Release of Patient Photographs

I consent to the taking and publication of photographs by Look Young Atlanta of
parts of my body in connection with the treatment or procedure(s) to be performed. I further authorize Look Young Atlanta or one of its associates to publish these photographs on its website or any other associated website for Look Young marketing or in the office photo albums.

I provide this authorization as a voluntary contribution in the interests of public education and marketing. I understand that such photographs shall remain the property of Look Young Atlanta and may be released by Look Young Atlanta for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. I do_____(initials) do not_____ give my permission to use photographs that make my identity recognizable (Weight loss patients will be indentified by body).

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Ouderkirk.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. John Ouderkirk and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature of Patient or Guardian Date

NOTICE OF PRIVACY PRACTICE

How we may use and disclose medical information about you: The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one or two categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Who Will Follow This Notice: This notice describes our practices' policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as employees, staff, and other practice personnel.

Policy Regarding Protection of Personal Information: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the medical information that identifies you and is kept private; gives you this notice of our legal duties and privacy practice with respect to medical information about you; and to follow the

terms of this notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders, as required by law, for health--related benefits and services, to individuals involved in your care or payment for care, research, to avert a serious threat to health or safety, and for treatment alternatives. Other uses for disclosure of your personal information could include: disclosure to, or for coroners, medical examiners, and funeral directors, health oversight activities, inmates, law enforcement, lawsuits and disputes, military and veterans, national security and intelligence activities, organ and tissue donation, protective services for the President and others, public health risks, and workers compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosure: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. To request this list or accounting, you must submit your request in writing to the Privacy Officer.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment or health care options. You also have
the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree with your request.* If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment. To request restrictions, you must make your requests in writing to the Privacy Officer.

Changes to this Notice: We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of Department of Health and Human Services. To file a complaint with the practice, contact John Ouderkirk, M.D. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time.

If have any questions about this notice or would like to receive more detailed information, please contact our Privacy Officer.

I acknowledge by signing that I have received the NOTICE OF PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS.

_____ _____

Patient Signature Date