VENTURE MEDICAL
WEIGHT LOSS & WELLNESS
PATIENT INTAKE FORMS
FOR THE INITIAL APPOINTMENT

All information that is collected contributes to the treatment for obesity
and we are required to collect it by the government of commonwealth of Kentucky

PATIENT INFORMATION (Please Print) **Today's Date: _____**

Name: _____ DOB: _____ Please Circle: M / F
(Last) (First) (MI) mm/dd/yyyy

Address_____

City_____ State _____ Zip Code_____

Social Security #_____
(needed for Government required review and reporting of Prescriptions of Controlled Substances to KASPER = KY All Controlled Substance Patient Electronic Record)

Phone# (mobile) (_____)-_____-_____ E-mail:_____

Do you currently have a PCP (Primary Health Care Provider?) YES / NO

Primary Care Provider: _____ Phone#_____
(We will discuss your health with your Primary Care Provider if necessary and required by law)

Emergency contact Name: _____ Relation: _____
contact number: _____
(We will contact your Emergency contact if necessary in case of an emergency)

_____

What is your occupation?……
…… ……

PRESCRIPTION MEDICATION REVIEW

For your safety and treatment in a weight loss program that could utilize controlled substances such as Phentermine, Laws of the commonwealth of KY require obtaining a medication review report (KASPER) for each patient. This report contains all controlled substances that are prescribed to you within the past year. Patients are also required to undergo random drug screening when in the program. Please mark for **ANY and ALL medications** you are **CURRENTLY (CURR) prescribed** or **have been prescribed in the PAST YEAR (PY)** (past 12 months).

MEDICATION	CURR	PY	MEDICATION	CURR	PY
Abstral (Fentanyl Transmucosal)			Lunesta		
Adderall (Dextroamphetamine)			Marinol (Dronabinol)		
Adipex-P (Phentermine)			Meperidine (Demerol)		
Alprazolam (Xanax)			Methadone		
Ambien (Zolpidem)			Methocarbamol (Robaxin)		
Amphetamines			Methylphenidate		
Ativan (Lorazepam)			Midazolam (Versed)		
Avinza (Morphine Sulfate)			Morphine		
Bontril (Phendimetrazine)			MS Contin/MS IR		
Butrans(Buprenorphine)			Naltrexone (Vivitrol/ReVia)		
Buprenex (Buprenorphine)			Neurontin (Gabapentin)		
Butalbital			Norco (Hydrocodone/Acetaminophen)		
Butorphanol			Norflex (Orphenadrine)		
Carisoprodol (Soma)			Nucynta (Tapentadol)		
Clonazepam (Klonopin)			Numorphone		
Clorazepate (Tranzene)			Orphenadrine		
Codeine			Oxycodone		
Concerta (Methylphenidate)			Oxycontin		
Cyclobenzaprine (Flexeril)			Oxymorphone		
Darvocet			Percocet (Oxycodone/Acetaminophen)		
Darvon			Percodan (Oxycodone/Aspirin)		
Demerol (Meperidine)			Propoxyphene (Darvon)		
Dexedrine (Dextromethamphetamine)			Rozerem		
Diazepam (Valium)			Revia		
Didrex (Benzphetamine)			Robaxin (Methocarbamol)		
Dilaudid (Hydromorphone)			Roxicet		
Dolophine (Methadone)			Roxicodone		
Duragesic (Fentanyl Transderm)			Soma (Carisoprodol)		
Duramorph			Stadol		
Endocet (Oxycodone/Acetaminophen)			Suboxone		
Esgic/Esgic plus			Subutex		
Fastin			Talacen (Pentazocine/Acetaminophen)		
Fentanyl			Talwin (Pentazocine)		
Fioricet/Fiorinal			Temazepam		
Flexeril (Cyclobenzaprine)			Tenuate		
Gabapentin (Neurontin)			Toradol		
Halcion (Triazolam)			Tramadol		
Hydrocodone (Lortab/Lorcet/Vicodin)			Triazolam		
Hydromorphone			Tylenol w/codeine (Tylenol #3)		
Ionamin			Tylox		
Kadian (Morphine)			Ultram (Tramadol)		
Ketorolac (Toradol)			Ultracet (Tramadol/Acetaminophen)		
Klonopin (Clonazepam)			Valium (Diazepam)		
Librium (Clordiazepoxide)			Vicodin (Hydrocodone)		
Lorazepam (Ativan)			Vivitrol		
Lorcet			Xanax		
Lortab					

Please list any additional medications you are **CURRENTLY prescribed** or **have been prescribed** in the PAST YEAR that do not appear on the above list.

Medications (list all medications that you take, prescribed, OTC, vitamins, natural supplements)

As required we routinely check for a history of ALL controlled substance medications in KY and other states, including CBD products, please do not forget to list every possible controlled substance.

Medication	Reason for taking	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **I do not take any medications** _____

Patient signature

Have you taken any weight loss medications before today? NO / YES **(if yes fill out below)**

When was the last time you took weight loss medications? _____

Medication Name	Dosage	Lost Weight?	List Side effects, if any
_____	_____	NO / YES	_____
_____	_____	NO / YES	_____

Laboratory Work-up & ECG History

In the Commonwealth of KY, ALL weight loss clinics are required to review patient labs at least once a year as part of your weight loss treatment. Additional labs may become necessary in the course of your treatment. All New and Re-Starting patients who intend to be prescribed with a controlled substance (such as Phentermine) are also required to submit to a Drug Screening test according to KY law 201 KAR 9:260.

Labs must include: CBC (Complete Blood Chemistry, no differential necessary),

CMP (Complete Metabolic Panel), Hemoglobin A1C (HbA1C),

Fasting Lipid Profile: **10-12 hour fasting required.** (Total cholesterol, LDL, HDL, VLDL, TG),

Thyroid Profile (TSH, with or without T3/T4) Baseline Drug Test (Urine or Blood)

Patients who have undergone Bariatric Surgery must also obtain Vit. A, B1, B9, B12, D, E, Iron Studies, Mg, Zinc, Uric Acid.

If you have certain medical conditions, an EKG and clearance from your Cardiologist may be necessary.

If you have had blood-work done elsewhere, please bring a copy of your lab results, or email it to us at Labs@VentureWeightLoss.com, or keep them ready by accessing MyChart for the doctor to see. We cannot accept photographs from your phone for lab results. Our patients get a substantial discount at Labcorp locations if prepaid at this office and we enter a lab order electronically for you. Labcorp makes the results available electronically to us as well as you via the patient portal.

WEIGHT LOSS HISTORY (circle or fill in as appropriate)

My Obesity Began: • Childhood • Puberty • Adult • After Pregnancy

• Other: _____

Have you attempted losing weight on your own without medication in the past? ❑ No ❑Yes ❑ many times

If yes, what was the outcome? _____

If you lost weight, did you reach your goal weight? ❑ No ❑Yes

After weight loss, are you able to maintain your weight? ❑ No ❑Yes

If not, what leads to regaining the lost weight for you? _____

CURRENT EATING HABITS: (circle or fill in as appropriate)

Are you an emotional or stress eater? YES / NO

Which emotions trigger eating for you? (e.g. sadness, happiness, anger, etc) _____

What is your current diet? (low/high calorie, low/high fat, low/high carbohydrate, mostly fast food, fried foods, vegetarian, vegan etc.)? _____

How many times per day do you eat? _____

Do you eat multiple small meals or a couple large meals each day? _____

Do you currently monitor your macronutrient intake (such as carbohydrates/fats/proteins)? YES / NO

If yes, what is the percentage of each? Carbs _____% Fat _____% Proteins _____%

Do you keep a food diary? YES / NO (If yes, which app do you use?) _____

Which of the following are your challenges that sabotage or come in the way of weight loss?

Portion size	Skipping Dinner	No enjoyment of food
Too many carbs or Sweets	Alcohol consumption	No consistency in behavior
Too few proteins	Fried foods	Sleep eating/wake up to eat
Skipping breakfast	Eating Out	Picky eating
Skipping Lunch	Eating mindlessly/boredom	

Which of the following do you think would best help you on your weight loss journey? (Circle or Check all that apply):

Learn proper portion size and how to control them	Learn what times are best for higher calorie meals
Healthy snack/meal options	Keeping a food journal
Learn to keep track of calorie intake	How much water should I drink per day
What my daily calorie intake should be	Learn about macros (carbs, proteins, fats)

My preferred diet: (Circle or Check all that apply):

Carb restricted	Fat restricted	Vegan
Calorie restricted	Weight Watchers	Clean eating

DASH or Mediterranean Diet	Diabetic diet	KETO
High protein	Portion control	

LIFESTYLE and BEHAVIORAL HISTORY:

Do you try weight loss diets (e.g., keto) or specialized diets (e.g., no sugar)	YES	NO
Do you engage in Excessive/compulsive exercise?	YES	NO
Do you find yourself Binge eating (spells of eating a lot of food at once)?	YES	NO
Do you or have you ever self-induced vomiting to reduce calories?	YES	NO
Have you tried laxative, diuretic, or over-the-counter diet pills to lose weight?	YES	NO
Have you ever chewed food and spit it out to lose weight?	YES	NO
Do you obsess with food cleanliness?	YES	NO
Do you feel overweight despite weight loss or low body weight?	YES	NO
Do you have any impulsive or irregular eating habits?	YES	NO
Have you ever used Insulin for weight loss?	YES	NO
Do you get distressed with feelings of disgust, depression, or guilt around food?	YES	NO

How often do you consume alcohol? _____drinks/day; _____x's/week or x's/month (enter zero "0" if you don't drink)
Do you use cocaine, marijuana or other drugs? YES NO If YES, what? _____
If you used to use cocaine, marijuana or other drugs, when did you quit? _____

If you consume alcohol cocaine, marijuana or other drugs, please respond to the following questions:

Have you ever felt you ought to cut down on your drinking or drug use?	YES	NO
Have people annoyed you by criticizing your drinking or drug use?	YES	NO
Have you felt bad or guilty about your drinking or drug use?	YES	NO
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	YES	NO

Do you smoke cigarettes or Vape? YES NO If yes, how much per day? _____
If YES, do you wish to quit smoking? YES NO If yes, what have you tried? _____
If you used to smoke, when did you quit? _____
How many hours of sleep do you get nightly on average? _____
Do you work a shift other than during the day (am to pm) if yes, specify _____
Do you consider your life, job, etc. to be stressful? _____
If so, how stressful on a scale of 1-10 (1 minimal, 10 severe) would you say your life is? _____

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DIETING HISTORY

How have you attempted to lose weight in the past? (Circle appropriate)

 Exercise Diet Medications Behavioral therapy Jenny Craig Wt Watchers

 NutriSystem Atkins Diet 17 Day Diet South Beach Diet Mediterranean Diet Other:

What were your outcomes with past weight loss attempts? _____

Your goal weight: _____ lbs.

Age when you were last at your goal weight: _____

What weight loss methods have been successful for you in the past? _____

What is the most you have weighed and when? _____

What is the least you have weighed and what year was this? _____

How many days per week do you get moderate exercise? (sweat breaking, heart pounding, breathing heavy) _____

What type(s) of exercise are you currently doing? _____

How compliant have you been with previous weight loss programs? _____

What were the barriers you faced in being compliant (time, motivation, etc.) _____

After losing weight in the past, were you able to maintain it? Keep it off? YES NO

If you maintain your weight? How long before you regained weight? _____

How long have you been at your current weight? (within +/- 10 lbs) _____

Restrictions: Have you ever had or currently have any exercise restrictions?

❑ No ❑Yes (specify)_____

Have you ever had or currently have any food restrictions?

❑ No ❑Yes (specify)_____

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MEDICAL HISTORY

When was your last physical exam? _____

- Have you had any allergic reactions to Penicillin, Sulfa or any other medications? _____
  If YES, what medications: _____
- Do you have any food allergies or sensitivities? _____

- Do you have a history of depression, paranoia, psychosis or chemical dependence? YES NO

  If yes, what do you have a history of? _____

  - Has your condition been treated? YES NO
  - How was your condition treated (any medications, if so, what?)

    _____

Family History (Please Check if your FIRST-DEGREE RELATIVES have any of the following conditions:

Heart Disease Cancer Diabetes Hyperthyroidism High Cholesterol High Blood Pressure

Stroke Kidney or Liver Disease Mental Illness Drug/ Alcohol Abuse

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you				
have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

If you checked off any problem on the above chart, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Review of Systems *CURRENT MEDICAL CONDITIONS*

Do you have or ever had any known Vitamin Deficiencies? **YES** **or** **NO** **(Circle one)**

If yes, which one? _____

Do you Take any vitamins or supplements, fibers, and stool softeners? **YES** **or** **NO** **(Circle one)**

If yes, which one? _____

PLEASE CIRCLE IF YOU HAVE ANY DISORDERS FROM ANY BODY SYSTEMS:

EENT: Hearing Loss / Vision Loss / Teeth problems /Mouth or Gum Disease / Glaucoma / blurry vision

Thyroid: Known HypoThyroidism (low-acting) / Known HyperThyroidism (high-acting)

Heart: High Blood Pressure / High Cholesterol / Know heart murmurs

Breathing: Insomnia / Sleep apnea / Snoring / Asthma / COPD

Gastro-Intestinal: constipation / diarrhea/ irritable bowel syndrome / diabetes

Genitourinary: difficulty with urination (describe……) / PCOS (polycystic ovarian syndrome)

Neurological/Psychological: stroke / seizures / headaches / depression

Joint problems: arthritis (do you know what type?).....

Any other not mentioned above? Any Cancer?: …….

Past Surgical History *PLEASE SPECIFY ANY SURGICAL PROCEDURE YOU HAVE HAD*

Heart Surgery? …… Wt Loss Surgery?……

Cancer Surgery? …… Hysterectomy? ……

Any other surgery? ……

For our WOMEN PATIENTS ONLY:

A detailed Gynecological history is important in your weight loss journey

Remember, if you are trying to or become pregnant, you should not be taking any weight loss medications.

Please circle appropriately if you are premenopausal postmenopausal perimenopausal

If not postmenopausal, when was your Last Menstrual Period? _____

Are your menstrual periods regular? **YES or NO (Circle one)**

Do you have heavy menstrual periods? **YES or NO (Circle one)**

Have you had any fertility problems? **YES or NO (Circle one)**

Ever diagnosed with PCOS (polycystic ovarian syndrome)? **YES or NO (Circle one)**

If yes, what treatment was or is being used? _____

Are you using any methods of contraception? **YES or NO (Circle one)**

If yes, what contraceptive method are you using? _____

If you delivered a baby recently, are you breastfeeding? **YES or NO (Circle one)**

How many children do you have, if any? _____

How many miscarriages have you had, if any? _____

Describe any complications of pregnancy, if any _____

Have you had Gestational Diabetes (GD)? **YES or NO (Circle one)**

If you had GD, how was it treated? _____

Informed Consent

(that means, you are giving us permission to treat you for weight loss after receiving all information and making a decision to seek treatment)

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through discussions and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the use of medicines, length of use of medicine, or medication dosing may be used in an "off label" manner. This means the doctor may be using the medicines safely in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine. Please note that the use of medications for weight loss is optional, and no weight loss treatment (including use of medications) guarantees successful weight loss.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.

2. Devote the time and effort necessary to complete and comply with the course of treatment.

3. Allow us to share information with your personal physician if necessary.

4. Make and keep follow-up appointments so that we can help you the best, allowing necessary blood tests as needed. Patients more than 15 minutes late for an appointment may be rescheduled to another day.

5. Advise the clinic staff and Dr. of any concerns, problems, complaints, symptoms, or questions you develop.

6. Inform your personal physician of your weight loss efforts and have or establish a primary physician before beginning this program.

Possible Side Effects

1. Reduced weight. By reducing your caloric intake, you may see a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects, particularly if you exceed the dosage without being directed by the physician. This will be closely monitored as safety is our number one priority.

2. Reduced potassium levels or other electrolyte abnormalities. We monitor electrolyte levels and correct them if they become too low. If they were not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.

3. Gallstones. Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.

4. Pancreatitis. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.

5. Pregnancy. Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.

6. Sudden death. Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.

7. Risk of weight gain – Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain it unless in some type of maintenance program and long-term efforts at controlling the weight are continued. Remember, your weight loss is not permanent unless your behavior modification and lifestyle changes are permanent as well. We will provide you with a plan to prevent weight from returning.

Patient

Signature_____ Date_____

Witness :_____ (Medical Staff only)

IF YOU WOULD LIKE A COPY OF THE POSSIBLE SIDE EFFECTS PLEASE ASK THE RECEPTIONIST.

RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.

I, (print your name) _____, wish to enter into the weight loss program directed by Venture Medical Weight Loss LLC. I understand this program includes diet, exercise, behavioral & lifestyle changes, and appetite suppressants when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and illegal.

Appetite suppressants are controlled substances that are regulated by State and Federal Laws. I understand pursuant to State and Federal Laws prescriptions for controlled substances cannot be filled any sooner than once every four weeks. I understand I will not and cannot, for any reason, receive refills on prescriptions for appetite suppressants any earlier than once every four weeks.

I understand that it is illegal to obtain appetite suppressants from more than one physician and agree I will not obtain any appetite suppressants from other prescribing physicians. I further understand it is illegal to use more than one pharmacy to have multiple prescriptions filled for appetite suppressants. Use of appetite suppressants that are controlled substances is monitored by a Patient Drug Monitoring Program (PDMP) in each state, and is called KASPER in Kentucky. Venture Weight Loss has access to all of the 50 states in the USA that participate in the PDMP.

I agree to only participate in the weight management program directed by Venture Medical Weight Loss. I understand it is illegal to participate in any other weight management program that uses appetite suppressants while I am participating in the weight management program directed by Venture Medical Weight Loss.

I understand that if I participate in the acquisition of appetite suppressants from multiple healthcare providers, for any reason, I am participating in an illegal action and may be held liable for criminal activity.

I understand that my use or misuse of controlled substances including appetite suppressants is reportable to appropriate authorities of the commonwealth of Kentucky which also shares information with multiple patient drug monitoring programs (PDMP) of other states.

I verify I have noted any medications I **am CURRENTLY taking** or **have TAKEN** in the past 12 months. I further verify that I have correctly noted my current and past medical and surgical history, my family medical history, and have provided ALL correct information. I understand that any omissions may affect the efficacy of my treatment at Venture Weight Loss.

Date_____ Patient Signature_____

Witness_____ (Medical Staff)

KASPER (Kentucky All Substance Patient Electronic Record) Consent:

I understand that Kentucky law requires physicians prescribing controlled medications (including weight loss medications) to monitor patients' use of these medications. This monitoring includes an initial drug screening panel & KASPER report. I understand KASPER reports list what controlled substance prescriptions I have filled in the past several years. Further monitoring may include random drug screens, random pill counts, and repeat KASPER reports every three months while in the Venture Weight Loss program. Therefore, I understand that I am to bring in my unused weight loss medications to my appointments as they may be randomly required. I will cooperate with random pill counts. I will allow random drug tests of my urine and/or blood. I understand that this required monitoring could result in the delay and/or inability of my physician to prescribe these types of medications to me. I understand that weight loss medications may assist in weight loss, but that there is no guarantee they will do so. I understand weight loss medications can only be used with proper nutritional and behavioral modifications. Failure to comply with nutritional and behavioral modifications may result in physicians discontinuing medication. If weight loss is not improved with use of medications, I understand my physician will need to stop or change medications. I understand my physician can discontinue weight loss medications at any time & will do so if weight loss plateaus. I understand that if weight loss medications are used, the plan is to use them only during weight loss and then to taper off of them once goals have been met. I will be evaluated monthly to see if medications can and should be refilled. I understand that weight loss medications are just one option to assist in weight loss, but are not required to lose weight. There are many options for weight loss although all patients will be instructed on nutritional, behavioral, and psychological modifications. Just like any medication, weight loss medications can have a risk of side effects. Such side effects may include (but are not limited to), dry mouth, constipation, anxiety, jittery sensation, headache, insomnia, allergic reaction, heart palpitation (rare), elevated blood pressure (rare). Addiction is listed as a potential side effect (although this has not been reported if used as prescribed.) I understand it is my responsibility to notify my Venture Weight Loss physician if I have any side effects. If weight loss medications are used over 1 month, they should be tapered off unless you become pregnant or have a serious side effect from the medication in which case they can be stopped immediately. Failure to taper off of weight loss medications may result in rebound hunger, fatigue, depression, gain in weight, and other symptoms. I understand that if I desire to discontinue medications for any reason (including simple inability to continue the program), I will contact VMWL to obtain a proper exit plan based on my current medical conditions. Unused medications may be returned to Venture Weight Loss for proper disposal, or follow the guidelines at \Vww.fda.gov/consumer.

HIPAA Notice: Your Rights and Confidentiality You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care. From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained. Please note that our Physicians do not take calls outside Venture Weight Loss's office hours. If you feel you are experiencing a medical emergency at any time, go to the nearest emergency room immediately for treatment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION (HIPAA) Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law

enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody, coroners, medical examiners, funeral directors. Uses and Disclosures of information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. (Disaster Relief & Persons Involved in your case). If you object, please notify the Privacy Contact identified at the end of this document. Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Newsletter and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating. Your Right Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer. 1. To request additional restrictions. 2. To receive communications by alternative means. 3. To inspect and copy records. 4. To request amendment to your record. 5. To request accounting of certain disclosures. 6. To receive a copy of our complete confidentiality notice. 7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates. 8. To receive notice of a breach 9. Right to restrict certain disclosure to your health plan.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint. Privacy Officer Contact: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact Dr. M. Kanvinde at our office located at 3700 Alexandria Pike Ste B, Cold Spring, KY 41076.

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

Notification: Unless you authorize us in writing, we will not be able to discuss any information about your health, including your appointment times with any person. If you wish to authorize any one to receive such information please indicate below:

Person(s) Authorized to Receive Information: _____

Physician Office(s) Authorized to Receive Medical Information:_____

Contact information: _____

Patient Signature_____ Date_____

Witness :_____ (Medical Staff only)

ALL FEMALE PATIENTS SHOULD READ AND SIGN THIS PAGE

Females only: I certify that I am not pregnant or breastfeeding. I agree and understand that I must notify my prescriber if I plan to become pregnant, start breastfeeding or am unsure if I am pregnant. I agree not to take weight loss medications if I become pregnant or start breastfeeding.

PLEASE NOTE:

The medical providers and staff of Venture Medical Weight Loss recommend and strongly encourage the consistent use of contraception to avoid pregnancy during treatment with our medications for ALL females of childbearing age. This is due to the increased risk of teratogenicity (fetal harm/damage) with the use of our medications.

By signing below, I am stating that I have read this document and understand the importance of using contraceptive methods while taking these medications. I understand if I should become pregnant, I should discontinue the use of these medications immediately and report my pregnancy to Venture Weight Loss and its health care providers.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

_____ _____

Witness Signature (Medical Staff Only) Date