General Assessment

Name: _____ Date: _____ Age: ____ Sex: F/M

What is your health goal?

Please list 5 health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any medications and/or supplements you are currently taking:

_____
_____
_____
_____
_____

Please circle the appropriate number corresponding to how/if you experience the symptom listed.

Gastrointestinal				
Diagnosis of Celiac, Crohn's, Colitis or IBS (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Diarrhea (very loose or > 3 bowel movements/day)	0	1	2	3
Constipation	0	1	2	3
Difficulty with fatty foods	0	1	2	3
GERD/Reflux	0	1	2	3
Belching, burping	0	1	2	3
Frequent use of antibiotics	0	1	2	3
Stomach pain (cramps, burning, gnawing)	0	1	2	3
Yeast Overgrowth				
	None	**Mild**	**Moderate**	**Severe**
Gas	0	1	2	3

Bloating	0	1	2	3
White tongue	0	1	2	3
Foul smelling gas	0	1	2	3
Rectal itching	0	1	2	3
Toe fungus, jock itch, athletes foot	0	1	2	3
Bad breath	0	1	2	3
Toxicity/Environmental Exposures				
Gallbladder removed (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Use or around pesticides	0	1	2	3
Frequent dry cleaning	0	1	2	3
Around leakage, wet carpets, or water damage	0	1	2	3
Feel better when I leave my home	0	1	2	3
Bitter metallic taste in the mouth	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Itchy skin	0	1	2	3
Reddened skin	0	1	2	3
Eat fish 3 or more times a week	0	1	2	3
Inflammation/Pain/Musculoskeletal				
	None	**Mild**	**Moderate**	**Severe**
Fibromyalgia (widespread musculoskeletal pain)	0	1	2	3
Headaches/migraines (non-hormonal—not assoc. w/periods)	0	1	2	3
Joint pain	0	1	2	3
Muscle aches	0	1	2	3
Early morning stiffness	0	1	2	3
Swelling	0	1	2	3
Frequent use of NSAIDS (ex. Aspirin, Advil, Aleve, Celebrex)	0	1	2	3
Decreased range of motion	0	1	2	3
Cognitive				
Diagnosis/feelings of: depression and/or anxiety (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Poor memory	0	1	2	3
Poor concentration	0	1	2	3
Mood swings	0	1	2	3
Nervous System				
	None	**Mild**	**Moderate**	**Severe**
Numbness/Tingling	0	1	2	3
Diminished sensation of hot or cold	0	1	2	3

Female Hormones (if applicable)				
Diagnosis of Menopause (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Hot flashes	0	1	2	3
Brain fog (dysfunction in focus, learning and/or memory)	0	1	2	3
Insomnia (difficulty in falling and/or staying asleep)	0	1	2	3
Osteopenia or Osteoporosis (bone thinning)	0	1	2	3
Dry/thin skin	0	1	2	3
Still Menstruating (circle) YES/NO				
Diagnosis of Endometriosis, PCOS or Fibroids (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Fertility issues (trouble becoming pregnant or maintaining to term)	0	1	2	3
Cramps (associated with menstrual cycle; mid-cycle, during, etc.)	0	1	2	3
Breast tenderness (ex. Fibrocystic breast diagnosis)	0	1	2	3
Cycles greater than 32 days or less than 24 days	0	1	2	3
Pain with period	0	1	2	3
Light blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Irritability with period	0	1	2	3
Headaches with period	0	1	2	3
Poor libido (sex drive; desire for sex)	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss or thinning	0	1	2	3
Male Hormones (if applicable)				
	None	**Mild**	**Moderate**	**Severe**
Poor libido (sex drive; desire for sex)	0	1	2	3
Erectile dysfunction (trouble getting or maintaining erection)	0	1	2	3
Fatigue	0	1	2	3
Irritability	0	1	2	3
Poor muscle mass (or loss of muscle mass)	0	1	2	3
Weak urine flow (or trouble emptying bladder)	0	1	2	3
Adrenal				
	None	**Mild**	**Moderate**	**Severe**
Fatigue	0	1	2	3
Dizziness or lightheaded	0	1	2	3
Shaky or irritable when hungry	0	1	2	3
Salt cravings	0	1	2	3
Feel worse with exercise	0	1	2	3
Get a second wind (renewed energy) at night	0	1	2	3

Wake up feeling unrefreshed (even if appropriate sleep)	0	1	2	3
Stress makes things worse	0	1	2	3
Difficulty sleeping at night	0	1	2	3
Use of steroids (testosterone, cortisone, prednisone, etc.)	0	1	2	3
Anxious	0	1	2	3
Headaches with stress	0	1	2	3
Thyroid				
Diagnosis of Hashimoto's or Graves (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Fatigue	0	1	2	3
Weight gain	0	1	2	3
Constipation	0	1	2	3
Thinning hair and/or breaking nails	0	1	2	3
Menstrual irregularities	0	1	2	3
Cold hands and feet	0	1	2	3
Feeling blue or depressed	0	1	2	3
Sleep excessively when given opportunity, 9 hours or more	0	1	2	3
Dry skin	0	1	2	3
Mental sluggishness	0	1	2	3
Cardiovascular				
Diagnosis of high blood pressure (circle) YES/NO				
Diagnosis of high cholesterol (circle) YES/NO				
History of Stroke or TIAs (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Chest tightness/Angina	0	1	2	3
Arrhythmia (improper heart beats – too fast, too slow, irregular)	0	1	2	3
Palpitations (**noticeably** rapid, strong or irregular)	0	1	2	3
Pulse higher than 80 bpm (beats per minute) at rest	0	1	2	3
Immune				
Diagnosis of an Autoimmune Disease such as Lupus, Rheumatoid Arthritis , Multiple Sclerosis, Graves, Psoriasis, Sjögren's, Hashimoto's, Addisons', Scleroderma, Celiac or another (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Low white blood cell count	0	1	2	3
Takes more than 3-4 days to recover from a cold	0	1	2	3
Lymph nodes that swell and shrink (return to normal)	0	1	2	3
Fatigue that had a sudden onset	0	1	2	3
Frequent or recurrent infections	0	1	2	3
Frequent use of antibiotics	0	1	2	3

Allergies				
	None	**Mild**	**Moderate**	**Severe**
Seasonal issues	0	1	2	3
Sensitivities to foods	0	1	2	3
Hives	0	1	2	3
Headaches	0	1	2	3
Itching	0	1	2	3
Rashes	0	1	2	3
Eczema (itchy, scaly rash, sometimes reddish)	0	1	2	3
Shortness of breath	0	1	2	3
Chest tightness	0	1	2	3
Metabolic				
Diagnosis of Diabetes type 2, Metabolic Syndrome or Polycystic Ovary Syndrome (circle) YES/NO				
	None	**Mild**	**Moderate**	**Severe**
Weight gain	0	1	2	3
Frequent thirst and urination	0	1	2	3
Numbness or tingling	0	1	2	3
Poor wound healing	0	1	2	3
Reoccurring yeast infections	0	1	2	3
Fatigue after meals	0	1	2	3
Sugar cravings	0	1	2	3
Eat sugar daily (or refined carbohydrates)	0	1	2	3
Gain weight around the middle	0	1	2	3
Gain weight easily even with minimal carbohydrate/sugar intake	0	1	2	3

Please return to Family Weight & Wellness Clinic
or fax to 281-367-0605.

If you haven't booked your Hormonal Consultation, call today! 281-292-2300
www.DrRichardson.com

Consent for Bioidentical Hormone Restoration and Nutritional Therapy

Please initial each statement and sign at the bottom. Please discuss any questions with your health care provider before signing.

_____ I understand that nutritional supplementation and hormone restoration (HR) for improved health, quality of life, and disease prevention are not broadly accepted medical practices, and there are no guarantees with respect to such treatment.

_____ I hereby consent to the administration of hormones and nutritional supplements by Family Weight & Wellness Clinic's Health Care Providers (FWWC-HCP) for the purpose of restoring optimal levels and/or effects of same—even when initial levels are within laboratory reference ranges.

_____ I understand that FWWC-HCP practice is based upon interpretation of research and on the patient's response to therapy and may not conform to the guidelines issued by some medical organizations. We do not rely *solely* upon the TSH test for diagnosing thyroid insufficiency or monitoring treatment.

_____ I am seeing FWWC-HCP for HR only and do not hold them responsible to diagnose other diseases or to determine the ultimate cause of a hormone deficiency. I will consult my primary care doctor, endocrinologist, or other specialist for such services.

_____ I understand that with HR there are risks and possible complications if I do not comply with the recommended dosages and follow up tests. I agree to administer the hormones as directed and will have tests done when ordered. I agree to report to FWWC-HCP any adverse reactions or problems that might be related to HR.

_____I understand that I may be offered pharmacy-compounded or over-the-counter products, whose active ingredient is a human hormone or a nutrient that has been well-studied, but that the products themselves may not necessarily be FDA-approved. FWWC-HCP will determine the proper dose using lab testing and my clinical response.

_____I have been informed that in persons who have a predisposition, thyroid and/or cortisol replacement therapy may trigger atrial fibrillation, a heart rhythm disorder that affects 25% of people in their lifetime. This may require drug therapy, hospitalization, and/or electrical cardioversion. If I have persistent palpitations, rapid heart rate, or shortness of breath I will need to seek medical care from my primary physician or an emergency room.

_____ Women only: I do not hold FWWC-HCP responsible to perform screening tests. I will consult with my primary care physician or gynecologist concerning bone density scans, breast exams, mammograms, and PAP smears, and concerning the need for vaginal ultrasounds and biopsies while on HR. I understand that HR does not eliminate and may even increase the chance of pregnancy before menopause and will take appropriate precautions to prevent pregnancy (IUD, condoms, etc.). I have been informed that while combined transdermal estradiol and oral/transdermal progesterone therapy has not been shown to increase the risk of blood clots, heart attacks, and strokes or breast or uterine cancer; it may not prevent these disorders; they may still occur.

_____ Men only: I do not hold FWWC-HCP responsible to perform prostate cancer screening: PSA tests and rectal exams. I will decide whether to undergo such screening in consultation with my primary care physician or urologist. I have been informed that while testosterone supplementation has not been shown to increase the risk of heart attacks, strokes, or prostate cancer, it may not prevent these disorders; they may still occur.

I have read, understand and agree to all of the above statements.

Patient Signature _____ Date _____

25329 Budde Rd STE 402, The Woodlands, TX 77380 • Phone 281-292-2300 • Fax 281-367-0605

OFFICE POLICY AGREEMENT

As a patient of Family Weight & Wellness Clinic•Medi-Spa, I agree to adhere to office policies stated below. I understand that these policies are in place to ensure that my care is not delayed or interrupted due to scheduling or financial issues. I also understand they are in place to ensure that the schedules of the health care providers and other patients are not delayed or interrupted.

- I agree to arrive at least 15-20 minutes (or 30 minutes if I am a new patient) prior to my scheduled appointment time to check in and complete or update any patient information forms. As a courtesy to other patients, we request that you arrive on time. If you arrive later than your designated appointment, you may be asked to reschedule.
- I understand that it is my responsibility to provide current and complete personal and medical information, contact addresses and phone numbers, prior to my appointment and on an ongoing basis afterward.
- I understand that all the payments must be paid prior to my appointment and if I am unable to do so, my appointment will be rescheduled.
- As a part of my health monitoring while participating in the weight management program, I understand that after my initial visit, I will have a repeat ECG (electrocardiogram) performed six (6) months later, and then yearly after that. I will have screening blood work on my initial visit, and if results are normal, this testing will be performed yearly. **These monitoring procedures may be performed at different intervals if my medical condition(s) warrant more frequent monitoring.**
- If I am unable to keep my appointment, I understand that I must notify Family Weight & Wellness Clinic•Medi-Spa at least 24 hours before my appointment time. After two no-shows without 24-hour advance notification, my account will be charged with a no-show fee per incident at $25 per no show for an office visit.
    - The no-show fees are part of my account balance and must be paid BEFORE my next appointment can be scheduled.

I agree to adhere to all the above office policies of Family Weight & Wellness Clinic•Medi-Spa.

_____	_____	_____
Name (Printed)	**Signature**	**Date**

PATIENT FINANCIAL AGREEMENT

Thank you for allowing our office the privilege of serving your medical needs. Family Weight & Wellness Clinic•Medi-Spa is a place where the genuine care and welfare of our clients is our highest mission. That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.
   For your convenience, we accept cash, Master Card, Visa, Discover, American Express and CareCredit. ***We do apologize for any inconvenience as we do not accept checks.***
2. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract**. Therefore, you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
3. If any Pre-certifications are required by your insurance company for any testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office cannot be held responsible.
4. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing Family Weight & Wellness Clinic•Medi-Spa to send your complete medical records to your insurance company once they are requested.

Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A photocopy of this document shall be considered as effective and valid as the original.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

No Show / Cancellation policy Effective March 1, 2019

Due to the nature and availability of our practice it is important to us that we have a No show / Cancellation policy in place. This also will give our guests on the waiting list an opportunity to be seen earlier if possible.

Therefore, we require at least a **24 hour notice prior to your wellness appointment or 48 hour notice prior to your cosmetic appointment if you are unable to keep it as scheduled**. If you do not call to cancel your appointment within that 24 hour wellness or 48 hour cosmetic window, there will be a $50 fee charged to your credit card at the end of that business day.

CREDIT CARD AUTHORIZATION:

Patient name: _____

Name on card: _____

CC #: _____

CC type (circle): MasterCard VISA AMEX Discover CareCredit

Exp date: _____ 3 digit code _____

Cardholder signature: _____ Date: _____

By signing, I understand and I have read the No Show/ Cancellation Policy for Family Weight & Wellness Clinic•Medi-Spa.
This policy will also help us expedite any orders, supplements or cosmetics you may need shipped directly to you from our office the same day the order is placed.

OR

DISCONTINUE CREDIT CARD BILLING:

By discontinuing my credit card authorization, I understand my account will still incur charges as set forth in the No show/ Cancellation policy. Also, as a new guest, with this discontinuation or without a valid credit card on file, I understand I am not guaranteed that my appointment time will be held without confirmation.

Date: _____ Signature: _____

NOTICE TO ALL MEDICARE, MEDICAID, CHAMPUS, WPS &/ OR TRICARE BENEFICIARIES

Family Weight & Wellness Clinic•Medi-Spa does not participate in Medicare, Medicaid, Champus, WPS or TriCare programs and has chosen to opt out of Medicare. Family Weight & Wellness Clinic• Medi-Spa has found that due to the minimalistic fees allowed by these government agencies, we are unable to meet overhead expenses. Family Weight & Wellness Clinic•Medi-Spa is a Free Enterprise and would like to be able to extend quality medical care to you; however, due to the rules instituted by the government of the United States pertaining to these government agencies, the practice is unable to administer medical care to patients covered by them unless you read and sign the attached Waiver.

WAIVER

I understand that Family Weight & Wellness Clinic•Medi-Spa is not a Medicare, Medicaid, Champus, WPS or TriCare provider and has chosen to opt out of Medicare.

I accept full financial responsibility for any charges incurred.

Further, I understand that by signing this form, I waive my right to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services. Additionally, I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file to any other insurance policies.

☐ I do not have Medicare or Medicaid

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

HIPAA POLICY

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The term of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how we protect health information about you if it's used, disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ❖ Protected health information may be disclosed or used for treatment, payment, or health care operations.
- ❖ The practice has a Notice of Privacy Practices and that the patient has the opportunity to review the notice.
- ❖ The practice reserves the right to change the Notice of Privacy Policies.
- ❖ The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- ❖ The patient may revoke this consent at any time and all future disclosures will then cease.
- ❖ The practice may condition treatment upon execution of this consent.

I authorize Family Weight & Wellness Clinic•Medi-Spa to release my medical records or insurance information as necessary to process my medial claims and coordinate or manage my health care.

Due to HIPPA, the following information must be updated **by each patient annually**:

HIPAA - ACKNOWLEDGEMENT OF REVIEWOF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers/Email of individuals who are authorized to receive my medical information:

1 _____

2 _____

3 _____

4 _____

(Circle Y or N)
Y N It is ok to send me an e-mail
Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

1. ____ OK to leave a message re: items such as lab results, vitamins, refills etc.
2. ____ Please do not leave specific message but a general message is OK.
3. ____ Do not leave any messages at all.

_____
Signature of Patient / Parent if minor

_____ _____
Printed Name of Patient Printed Name of Parent if minor

_____ _____
Date Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guidelines. A copy of these guidelines is available upon request.