LIFESTYLE
SOLUTIONS MEDSPA
BEAUTY THROUGH HEALTH

New Patient Information

First Name: _____Last Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____Home Phone: _____ Email: _____

Preferred method of communication: ____Mobile Phone ____Home Phone ____Email

Date of Birth: _____ Age: _____ Marital Status: _____ Gender: ___Male ___Female

Social Security: _____ Driver's License: _____

Responsible Party (if a minor): _____Mobile Phone: _____

Emergency Contact: _____Relationship: _____Phone _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile phone: _____ Home phone_____

What is the reason for your visit today?

_____Weight Loss _____MedSpa Services _____Botox/Dermal Fillers

How did you hear about us?

_____Billboard _____Magazine _____Website _____Internet _____Other:_____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. Holloway & Staff for your weight loss needs. We are honored to be of service to you. This is to inform you of our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, Care Credit, Flex Spending Accounts, cash and checks. A $35 fee will be charged for any returned checks.

All pre-paid treatment regimens are non-refundable. In the event that you are unable to complete a pre-paid treatment regimen, you could finish the treatment at a later date. (Up to one year from your last appointment)

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient Signature Date

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Office and Financial Policies

We would like to thank you for choosing Lifestyle Solutions MedSpa (LSM) for your medical and aesthetic needs. As one of our clients we would like to keep you informed of the current office and financial policies. Please read each of the following sections carefully and initial:

Insurance: LSM does **NOT** participate with or submit billing for any private insurance companies. However, Dr. Holloway does use diagnosis codes and we can provide you with a copy of your Super Bill upon request so that you are able to complete the appropriate forms for patient reimbursement from your insurance company _____**Initial**

Payment: ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE; however, some services may require a deposit in advance. LSM only accepts payment in the form of cash, check, VISA, MasterCard, American Express, Discover, Care Credit and Flex Spending Accounts**.** _____**Initial**

Refund Policy: ALL SALES ARE FINAL. Before a service is performed please consider all the required protocols and side effects. We are committed to client satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer before purchase. LSM may provide patients with prescription medication and if so are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription medications for refund. _____**Initial**

Appointments: Missed appointments represent a cost to us, to you and to other clients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. **There is a charge of $25.00 for missed or late cancelled appointments**. Excessive abuse of scheduled appointments may result in discharge from the practice. _____**Initial**

Package Agreement: All Weight Loss, Injectable, SmoothShapes, Laser Procedures, Skin Facials, Massages and/or any other custom packages are all **NON-REFUNDABLE** and cannot be substituted for any other packages. _____**Initial**

Prescription Medication: Many of the medications that are prescribed by Dr. Holloway are deemed as controlled substances and must be monitored regularly. All patients are required to have an initial appointment with Dr. Holloway and must be monitored on a monthly basis in order to receive any prescription refills. The controlled medications will be dispensed in the office at the time of your visit. _____**Initial**

Lab Work: Bloodwork and EKG testing are mandatory for all weight loss programs. I understand that this testing needs to be completed within the first week following my initial appointment. I also understand that if the results are not received by this establishment prior to my third appointment, that I will not be prescribed any additional medication. All testing must be repeated yearly at a minimum. _____**Initial**

Services Policy: I understand LSM has the right to refuse treatment and/or dismiss a client from any service at any time. I also understand that I may not be a candidate for certain medical services and it is at the full discretion of the medical provider to determine whether I am a candidate for any service provided. _____**Initial**

I have read, understand and agree to the office and financial policies set forth by Lifestyle Solutions MedSpa.

Patient or Guardian Signature: _____ Date: _____

Patient's Name (Please Print):_____

At your request, a copy of these policies can be provided for you.

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Medical History

Name: _____ Age: _____ Sex: M F

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Do you have a primary care physician? Yes No

   If yes, Who? _____

3. Are you taking any medications at the present time? Yes No

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

4. Any allergies to any medications? Yes No What: _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   How Many Years? _____ Insulin Injections? Yes No Dosage?_____

7. History of Heart Attack or Chest Pain? Yes No When? _____

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

10. History of Constipation? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History (Women Only):

    LMP: _____ Number of Pregnancies: _____ Last Check Up: _____

    Hormone Replacement Therapy: Yes No
    What: _____

    Birth Control Pills: Yes No
    Type: _____

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Medical History
(Continued)

13. Serious Illnesses, Injuries, Hospitalizations or Surgeries: Yes No

Specify: _____Date: _____

Specify: _____Date: _____

Specify: _____Date: _____

Specify: _____Date: _____

14. History of Gastric Bypass Surgery, Lap Band, or Stomach Stapling: Yes No

15. Do you Smoke? Yes No
How Much: _____

Consume Alcoholic Beverages? Yes No
How Much: _____

16. Family History

Father Living? Yes No Cause of Death: _____Age_____

Mother Living? Yes No Cause of Death: _____Age_____

Is there any Family History of:

Heart Disease/Stroke:	Yes	No	Cancer:	Yes	No
Diabetes:	Yes	No	High Blood Pressure:	Yes	No
Epilepsy:	Yes	No	Alcoholism:	Yes	No
Asthma:	Yes	No	Obesity:	Yes	No
Kidney Disease:	Yes	No	Psychiatric Disorder:	Yes	No
Tuberculosis:	Yes	No			

Past Medical History: (check all that apply)

_____Alcoholism	_____Fatigue	_____Migraine Headaches
_____Anemia	_____Fibromyalgia	_____Multiple Sclerosis
_____Anorexia	_____Gastric Reflux	_____Pneumonia
_____Arthritis	_____Gout	_____Polio
_____Asthma	_____Heart Disease	_____Prostate Problems
_____Back Pain	_____Hepatitis	_____Psychiatric Care
_____Bleeding Disorder	_____Hernia	_____Rheumatic Fever
_____Bulimia	_____High Cholesterol	_____Sleep Apnea
_____Cancer	_____HIV	_____Stroke
_____Diabetes	_____Kidney Disease	_____Thyroid Disease
_____Emphysema	_____Knee Pain	_____Tuberculosis
_____Epilepsy	_____Liver Disease	_____Ulcers

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health status.

_____ _____ _____

Signature of Patient (or Legal Guardian) Print Name of Patient/Guardian Date

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Nutrition and Exercise Evaluation

1. Present Weight: _____ Height: _____ Goal Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____

   _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____

   _____
6. What has been your maximum lifetime weight (non-pregnant)? _____ Year: _____
7. List any previous diets you have followed: _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. Do you struggle with controlling your appetite? Yes No
10. Do you feel you would benefit from medication to help you control your appetite? Yes No
11. Have you ever taken any form of prescription appetite suppressants? Yes No

    If yes, please list: _____
12. How many times per week do you eat out? Rarely 1-3 4-6 6+
13. Any Food Allergies: Yes No List: _____
14. Do you drink any of the following: sweetened coffee, sweet tea, regular soda, or energy drinks? Yes No
15. If Yes, How many daily? Rarely 1-3 4-6 6+
16. When you are under a stressful situation at work or family related, do you tend to eat more? Yes No
17. Describe your usual energy level: Very Low Low Moderate High
18. Describe your usual activity level: Inactive Light Moderate High
19. Please describe your general health goals and improvement you wish to make: _____

    _____

    _____

    _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

_____ _____

Signature Date

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Weight Loss Program Consent Form

I, _____, (patient/guardian) do hereby authorize Dr. Holloway and staff, to assist me with weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may include the use of appetite suppressants and fat burning injections. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up and show continued weight loss.

Regarding the use of appetite suppressants, as with any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart rate. I understand that these and other risks could be serious or in rare cases life threatening. **Initial: _____**

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Lifestyle Solutions staff immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. **Initial: _____**

I agree not to take any other weight loss medications, other than those prescribed by Dr. Holloway and further agree to inform the staff of ANY changes in my medication or medical history. **Initial: _____**

I understand that I can be successful without the use of appetite suppressants or injections as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications and injections may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain of the joints, gallbladder disease and even sudden death. **Initial:_____**

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling and at times in larger doses. Dr. Holloway is not required to use the medications as the labeling suggests but does use it as a source of information along with his own experience, the experiences of his colleagues, as well as recent studies and recommendations of investigators and professional societies. **Initial: _____**

I understand that there is no guarantee that this program will work for me. I understand that I must follow the program as directed in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by my insurance and Lifestyle Solutions does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out. **Initial: _____**

By signing below I certify that I have read and fully understand this consent form and understand the risks and benefits associated with my treatment for weight loss.

Patient Signature: _____ **Date: _____**