

2217 Woodsprings Road, Suite A

Jonesboro, AR 72404

P (870) 520-6241 F (870) 520-6254

**PATIENT REGISTRATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male or Female

Current Primary Care Provider and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Goal Weight: \_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

Thank you for selecting Defyne Med Spa and Weight Loss for your medical weight loss management. We are honored to be of service to you and your family. Please be advised that payment of all services is due at the time of check-in. We do not bill insurance, nor do we provide any information to insurance companies for any medical weight loss services rendered at Defyne Med Spa and Weight Loss. For your convenience, we accept all major credit cards, debit cards, cash or check.

I have read and understand all of the above and have agreed to these statements.**(Initial here) \_\_\_\_\_\_\_**

**Appointment Policy**

**I understand that my appointment today is to discuss weight loss only.** Any medical history, current problems or medications discussed will be used within the scope of weight loss only. We will not diagnose or treat any primary care issues during this visit (ie sinus infection, cough, gastritis, joint pain, etc).

**(Initial here) \_\_\_\_\_\_\_**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. **If an appointment is not cancelled at least 12 hours in advance you will be charged a twenty-five dollar ($25) fee.** This fee must be paid before your next appointment. **(Initial here) \_\_\_\_\_\_\_**

In order to continue receiving weight loss treatment, including any prescribed medications, you must attend appointments. **No early refills are allowed. Protect your medication; if it is lost or stolen it will not be replaced.** If you are unable to attend your scheduled appointment please call our office at 870-520-6241 and reschedule so that you may continue your weight loss success. You may leave us a message after hours or on weekends regarding rescheduling your appointment if necessary. **(Initial here)\_\_\_\_\_\_\_**

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 10 minutes past their scheduled time we will have to reschedule the** **appointment.** I have read and understand all of the above and have agreed to these statements. **(Initial here) \_\_\_\_\_**

**Current and Past Medical History**

***Please check all that apply:***

\_\_\_\_\_Currently trying to get pregnant \_\_\_\_\_High Blood Pressure

\_\_\_\_\_Currently breastfeeding \_\_\_\_\_Polycystic Ovarian Syndrome

\_\_\_\_\_Currently pregnant \_\_\_\_\_Diabetes Type I

\_\_\_\_\_Binge Eating \_\_\_\_\_Diabetes Type 2

\_\_\_\_\_Bulimia or Purging \_\_\_\_\_Hypothyroidism

\_\_\_\_\_Anorexia Nervosa \_\_\_\_\_High Triglycerides

\_\_\_\_\_Cirrhosis \_\_\_\_\_High Cholesterol

\_\_\_\_\_Congestive Heart Failure (CHF) \_\_\_\_\_Gallbladder diseases

\_\_\_\_\_Previous Stroke \_\_\_\_\_Chronic Constipation

\_\_\_\_\_Chest Pain \_\_\_\_\_Intestinal Obstruction

\_\_\_\_\_Heart Attack \_\_\_\_\_Stomach Ulcers

\_\_\_\_\_Abnormal Stress Test \_\_\_\_\_Gout

\_\_\_\_\_Abnormal Cardiac Catheterization/Stents \_\_\_\_\_Menopause

\_\_\_\_\_Tachycardia (fast heart rate)

\_\_\_\_\_History of open heart surgery (CABG graft)

\_\_\_\_\_History of blood clots (DVT, PE, etc)

\_\_\_\_\_Heart Murmur

\_\_\_\_\_Heart Value Disorder

\_\_\_\_\_Mitral Valve Prolapse

\_\_\_\_\_Glaucoma

\_\_\_\_\_Hyperthyroidism

\_\_\_\_\_Seizure

Please list any additional medical history not mentioned above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

List all of medications you currently take including prescription, vitamins, minerals and herbs, hormones, birth control pills.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

Please list any medical or food allergies below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY**

Previous Surgeries:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OB/GYN HISTORY**

Do you still have periods? Yes □ No □

Have you had a Hysterectomy? Yes □ No □

Have you had a tubal ligation? Yes □ No □

Do you have regular monthly menstrual periods? Yes □ No □

If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Control Yes □ No □ If yes, what form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Please fill in the information below. Place a check mark in the box if there is a history of the stated illness, if the answer is no, please write N/A (not applicable).

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Living (L)  or  Deceased (D) | Age | Heart  Attack | Stroke | High  Cholesterol | High  Blood  Pressure | Diabetes | Overweight  or  Obese | Other |
| Mother |  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |  |  |

**SOCIAL HISTORY**

Have you ever smoked cigarettes? Yes □ No □ Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of drug abuse? Yes □ No □

History of alcohol abuse? Yes □ No □

**CURRENT EXERCISE:**

☐ Sedentary (No exercise regimen)

☐ Light (No organized exercise regimen.)

☐ Moderate (weekend golf, tennis, jogging, swimming, or cycling)

☐ Heavy (Routine participation in jogging, swimming, cycling, or active sports for at least 3 times

per week )

☐ Vigorous (Routine participation in extensive physical exercise for at least 60 minutes per session at least 4 times per week)

**DIET HISTORY**

When did you start having weight problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has been your maximum lifetime weight (non-pregnant)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have frequent food cravings? Yes □ No □

If yes what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a night time eater? Yes □ No □

Do **you** cook at home? Yes □ No □

Is your spouse, fiancée or partner overweight? Yes □ No □

Do you have any overweight children? Yes □ No □

**Your diet history will be discussed during your initial visit. All efforts are relevant, even those with minimal or no weight loss. Please list all significant diet efforts for the past 5 years.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diet Name** | **Year** | **Length of Effort** | **Weight Loss** | **Weight Regained** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Have you used weight loss medications in the past? Yes □ No □**

**If you have taken weight loss medication (OTC and prescription) please fill in the table below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diet Medication Name** | **Length of Time**  **Taken** | **Weight Loss** | **Weight Regained** | **Side Effects** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Labs:**

If you would like to have screening labs drawn today please check all that apply:

\_\_\_\_\_\_Complete Blood Count

\_\_\_\_\_\_Complete Metabolic Panel

\_\_\_\_\_\_Cholesterol Panel

\_\_\_\_\_\_Thyroid Stimulating Hormone

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_No, I have had or will have my labs drawn at my primary care provider’s office.

\_\_\_\_No, I do not want any labs drawn.

I understand that by declining to have labs drawn any abnormalities that would have been identified will not be evaluated and this could increase my risk for adverse effects using appetite suppressants

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_



2217 Woodsprings Road, Suite A

Jonesboro, AR 72404

P (870) 520-6241 F (870) 520-6254

1000 E. Matthews Ave, #B

Jonesboro, AR 72401

P (870) 336-4050 F (870) 336-4059

**Patient Informed Consent for Appetite Suppressants**

Please initial where it is indicated, after you have read this form.

**I. Procedure & Alternatives:**

1. I, (Name and DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. Stacy Wilbanks and whomever his designates as his assistant(s), to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for 12 or more weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling. **(Initial):\_\_\_\_\_\_**

2. I have read and understand my doctor’s statements that follow:

“Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

“Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

“I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help of the appetite suppressants.” **(Initial):\_\_\_\_\_\_**

3. I understand it is my responsibility to follow the instructions carefully and to report to the provider treating me for my weight loss any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. **(Initial):\_\_\_\_\_\_**

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. **(Initial):\_\_\_\_\_\_**

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed it, even though I would probably be hungrier without the appetite suppressants. **(Initial):\_\_\_\_\_\_**

**II. Risks of Proposed Treatment:**

I understand this authorization is given with the knowledge that the use of the appetite suppressants for 12 or more weeks and possibly in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal. **(Initial):\_\_\_\_\_\_**

**III. Risks Associated with Being Overweight or Obese:**

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to develop high blood pressure, diabetes, heart attack and heart disease, and arthritis of the joints. I understand these risks may be modest if I am moderately overweight but these risks can increase significantly the longer I stay overweight or the more weight I gain. **(Initial):\_\_\_\_\_\_**

**IV. Women Only:**

I understand that Phentermine or any other weight loss medication should not be taken during pregnancy, due to the chance of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on medication. **If I become pregnant or could possibly be pregnant, I will stop the medication immediately and contact both the clinic and my OB/GYN or primary care provider immediately.**

I have read and fully understand this consent form. I realize I should not sign this form if all items have not been explained to me and my questions have not been answered to my complete satisfaction. I have been given all the time I need to read and understand this form. [STOP: If you have any questions regarding the risks or hazards of the proposed treatment or any questions concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.] **(Initial):\_\_\_\_\_\_**

**V.No Guarantees:**

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to be very regimented in regards to diet and exercise over my lifetime if I am to be successful now and in the future. **(Initial):\_\_\_\_\_\_**

**VI. Patient’s Consent**:

I have read and fully understand this consent form. I realize I should not sign this form if all items have not been explained, or if I have any unanswered or partially answered questions concerning my proposed treatment plan. I have been urged to take as much time as needed in reading and understanding this form as well as talking with my provider. By signing this form I understand and agree to all things mentioned above and I have received a copy of these forms for my own personal records.

**(Initial):\_\_\_\_\_\_**

**WARNING**

IF YOU HAVE ANY QUESTIONS regarding the following: the proposed treatment plan, THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT PLAN, OR OTHER POSSIBLE TREATMENTS, ASK YOUR PROVIDER NOW BEFORE SIGNING THIS CONSENT FORM.

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WITNESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VII. PROVIDER DECLARATION:**

I have explained the contents of this document to the patient and have answered all the patient’s related questions. To the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above as part of a diet and exercise plan.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider’s Signature / Date**



**Patient Consent for Use and Disclosure   
of Protected Health Information**

I hereby give my consent for Defyne Med Spa and Weight Loss to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Jonesboro HealthCare Clinicdescribes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Defyne Med Spa and Weight Loss reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the following address: 2217 Woodsprings Road, Suite A, Jonesboro, AR 72404.

With this consent, Defyne Med Spa and Weight Loss may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Defyne Med Spa and Weight Loss may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Defyne Med Spa and Weight Loss may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Defyne Med Spa and Weight Lossrestrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Defyne Med Spa and Weight Loss to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Defyne Med Spa and Weight Loss may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Legal Guardian, if applicable