**PATIENT INFORMATION FORM**

Patient Name: (Last) (First) (MI)

Name you prefer to be called:

Address:

City: State: Zip:

Home Phone: Cell Phone:

Birthdate: Age:

Email Address: Social Security Number:

Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer Choose not to disclose Other gender category not listed

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

**Employment Information**

Employer: Occupation:

Employer Address:

City: State: Zip:

Work Phone: Ext:

**Emergency Contact**

Name: Relationship: Phone:

Primary Care Provider: Phone:

**Pharmacy and Labs**

Preferred Pharmacy:

Address: Phone:

Preferred Lab:

Address: Phone:

**Insurance**

Primary Insurance:

Secondary Insurance:

*Please present your insurance card to staff at the front desk.*

**Financial Policy**

Thank you for selecting [YOUR CLINIC NAME] for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

[FOR CASH-ONLY PRACTICES] Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept [PAYMENTS YOU ACCEPT (E.G., VISA, MASTERCARD, CHECKS, ETC.)].

[FOR PRACTICES ACCEPTING INSURANCE] Please be advised that payment for all services will be due at the time of services rendered, unless prior arrangements have been made. We accept some forms of insurance. Please discuss your insurance coverage with a staff member.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees, and court costs.

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

Signature Date

Printed Name

**OBESITY PROGRAM CONSENT FORM**

*(Sample form only; Consult with your attorney to ensure that the form is valid in your state.)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize [YOUR NAME] and associated healthcare providers, to help me in my weight-reduction efforts. I understand that my program may consist of a [LIST DIETARY APPROACHES] diet, increase in physical activity, instruction on behavior modification, and the use of anti-obesity medications.

I understand that any medical treatment may involve risks as well as benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks associated with obesity management programs are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and other heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with having obesity may include but are not limited to: high blood pressure; diabetes; heart attack; heart disease; cancer; arthritis of the joints, including hips, knees, feet, and back; sleep apnea; and sudden death. I understand that these risks may increase with additional weight gain.

I understand that there will be an initial appointment, and minimum of monthly follow ups to receive additional refills on medications. You may reschedule once monthly due to unforeseen circumstances and/or illness.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that my plan will be successful. I also understand that obesity is a chronic, lifelong condition that will require permanent changes in eating habits, activity level, and behavior to be effective.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

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

Patient’s Name (printed) Witness

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

Patient Signature Date

*(or signature of person with authority to consent for patient)*

**CONSENT FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS**

*(Sample form only; Consult with your attorney to ensure that the form is valid in your state.)*

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT [your clinic name] WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND [your name] DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only [YOUR CLINIC NAME] will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at [YOUR CLINIC NAME] and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at [YOUR CLINIC NAME] of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by [YOUR NAME]. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at [YOUR CLINIC NAME] are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at [YOUR CLINIC NAME].

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEW PATIENT MEDICAL HISTORY FORM**

Name: (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI)\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Date of Visit: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Phone: (Home/Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your weight is affect your life and health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Weight History**

When did you first notice that you were gaining weight?

🞏 Childhood 🞏 Teens 🞏 Adulthood 🞏 Pregnancy 🞏 Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? \_\_\_\_\_\_\_\_\_

How much did you weigh: one year ago? \_\_\_\_\_ Five years ago? \_\_\_\_\_ 10 years ago? \_\_\_\_\_

Life events associated with weight gain (check all that apply):

🞏 Marriage 🞏 Divorce 🞏 Pregnancy 🞏 Abuse 🞏 Illness   
🞏 Travel 🞏 Injury 🞏 Nightshift work 🞏 Job change 🞏 Quitting smoking 🞏 Alcohol 🞏 Drugs

🞏 Medication (please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Previous weight-loss programs (check all that apply):

🞏 Weight Watchers 🞏 Nutrisystem 🞏 Jenny Craig 🞏 LA Weight Loss 🞏 Atkins

🞏 South Beach 🞏 Zone diet 🞏 Medifast 🞏 Dash diet 🞏 Paleo diet

🞏 HCG diet 🞏 Mediterranean diet 🞏 Ornish diet 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your maximum weight loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your greatest challenges with dieting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever taken medication to lose weight? (check all that apply):

🞏 Phentermine (Adipex) 🞏 Meridia 🞏 Xenecal/Alli 🞏 Phen/Fen

🞏 Phendimetrazine (Bontril) 🞏 Topamax 🞏 Saxenda 🞏 Diethylpropion

🞏 Bupropion (Wellbutrin) 🞏 Belviq 🞏 Qsymia 🞏 Contrave

Other (including supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What didn’t work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional History**

How often do you eat breakfast? \_\_\_\_\_ days per week at \_\_\_\_\_:\_\_\_\_\_ a.m.

Number of times you eat per day: \_\_\_\_\_ What beverages do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get up at night to eat? Y / N If so, how often? \_\_\_\_\_ times

List any food intolerances/restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food triggers (check all that apply):

🞏 Stress 🞏 Boredom 🞏 Anger 🞏 Insomnia 🞏 Seeking reward   
🞏 Parties 🞏 Eating out 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings:

🞏 Sugar 🞏 Chocolate 🞏 Starches 🞏 Salty 🞏 Fast food  
🞏 High fat 🞏 Large portions

Favorite foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Exercise type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration: \_\_\_\_\_ hours \_\_\_\_\_ minutes Number of times per week: \_\_\_\_\_

Does anything limit you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ Do you feel rested in the morning? \_\_\_\_\_

Past medical history (check all that apply):

🞏 Heart attack 🞏 Angina 🞏 Gallbladder stones 🞏 Sleep apnea

🞏 High blood pressure 🞏 Stroke 🞏 Indigestion/reflux 🞏 Thyroid

🞏 High cholesterol 🞏 Diabetes 🞏 Celiac disease 🞏 Anxiety

🞏 High triglycerides 🞏 Gout 🞏 Pancreatitis 🞏 Depression

🞏 Infertility 🞏 Arthritis 🞏 Polycystic Ovarian Syndrome 🞏 Bipolar  
🞏 Glaucoma 🞏 Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgical history (check all that apply):

🞏 Gastric bypass 🞏 Gastric banding 🞏 Gastric sleeve 🞏 Gallbladder 🞏 Heart bypass   
🞏 Hysterectomy 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

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

Allergies: (Medications)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Food)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Smoking: 🞏 Never 🞏 Current smoker (\_\_\_\_\_ packs/day) 🞏 Past smoker (quit \_\_\_\_\_ years ago)

Alcohol: 🞏 Never 🞏 Occasional 🞏 Regularly (\_\_\_\_\_ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: 🞏 Never 🞏 Current 🞏 Past 🞏 Type of drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana: 🞏 Never 🞏 Current user (\_\_\_\_\_ times/day)

**Family History**

Obesity (check all that apply): 🞏 Mother 🞏 Father 🞏 Sister 🞏 Brother

🞏 Daughter 🞏 Son

Diabetes (check all that apply): 🞏 Mother 🞏 Father 🞏 Sister 🞏 Brother

🞏 Daughter 🞏 Son

Other (check all that apply): 🞏 High blood pressure 🞏 Heart disease 🞏 High cholesterol

🞏 High triglycerides 🞏 Stroke 🞏 Thyroid problems 🞏 Anxiety 🞏 Depression

🞏 Bipolar disorder 🞏 Alcoholism 🞏 Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History**

Age periods started? \_\_\_\_\_ Age periods ended \_\_\_\_\_

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Age of first pregnancy: \_\_\_\_\_ Age of last pregnancy: \_\_\_\_\_

**System Review**

(Check all that apply)

🞏 Recent weight loss more than 10 pounds

🞏 Recent weight gain more than 10 pounds

🞏 Acne 🞏 Skin rash 🞏 Cough

🞏 Snoring 🞏 Shortness of breath 🞏 Chest pain

🞏 Difficulty breathing when flat 🞏 Fainting/Blacking out 🞏 Palpitations

🞏 Swelling ankles/extremities 🞏 Abdominal pain 🞏 Bloating

🞏 Constipation 🞏 Diarrhea 🞏 Food intolerance

🞏 Dysphagia/difficulty swallowing 🞏 Indigestion 🞏 Nausea/vomiting

🞏 Increased appetite 🞏 Decreased appetite 🞏 Heartburn

🞏 Gas and bloating 🞏 Urinary frequency/urgency 🞏 Slow urine flow

🞏 Nighttime urination 🞏 Blood in stools 🞏 Back pain (upper)

🞏 Back pain (lower) 🞏 Joint pain 🞏 Muscle aches/pain

🞏 Dizziness 🞏 Headaches 🞏 Seizures

🞏 Weakness/low energy 🞏 Anxiety 🞏 Depression

🞏 Insomnia 🞏 Memory loss 🞏 Inability to concentrate

🞏 Mood changes 🞏 Nervousness 🞏 Loss of interest

🞏 Cold intolerance 🞏 Excessive sweating 🞏 Hair changes

🞏 Heat intolerance 🞏 Blood clots 🞏 Fatigue/tiredness

**(Women only)**

🞏 Absence of periods 🞏 Hot flashes 🞏 Change in bladder habits

🞏 Abnormal/excessive menstruation 🞏 Facial hair

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Missed Appointment and Cancellation Policy

We’re glad you have chosen us to provide care for you. If you miss your appointments, you compromise your care. We want to remind you of the our office policies regarding missed appointments and cancellation fees.

If your treatment appointment is missed or not canceled within 24 hours, a late cancellation or missed appointment fee of $100 will be sent to your respective address.

A missed appointment is when you fail to show up for an appointment without a phone call, voice/text message, or cancel without prior notification. We strive to be on time for your scheduled appointment and ask that you give the same courtesy when you are unable to keep your appointment. We have outlines our missed appointment policies below.

Office Visits

* We require a 24 hour notice for all office visits otherwise a $100.00 missed appointment or cancellation fee will be charged.
* If you are sick less than 24 hours will be considered on individual basis.
* We will keep a copy of an active form of payment on file

By signing below, you agree you fully understand our policy

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

Printed Name

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

Patient Signature Date

**Magnolia Aesthetics, Inc.**

Darya Zakirov, MSNFNP

Ruslan Zakirov, FNP

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that without a valid referral

authorization from any Primary Care Physician that I am responsible to pay for

Services rendered for today’s visit. I understand that my Primary Care

Physician can issue valid referrals **AFTER** the services are rendered. I hereby agree to

pay for services rendered on the date below.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18, parent’s signature

Date of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_