NEW PATIENT REGISTRATION FORM FOR WEIGHT LOSS

Patient Information:

Name: ________________________________ DOB: _________ Sex: ________

SSN#:__________________________

Address: ________________________________ Apt: _________

Zip Code: ________________ City / State: ______________________________

Primary Phone #: ____________________ Emergency Phone #: _______________________

Email Address (write clearly): ____

By providing my email, I consent to receive medical records, billing statements and be contacted via email.

Pharmacy Info (This is where we will send your prescriptions)	
Pharmacy Name: ____________________	Preferred Location:__________________________________

Health History:

Allergies:	**Reaction:**

Current Medications and Daily Supplements:			
Medication Name:	**Dosage:**	**How Often:**	**Reason for Medication:**

Consent to Medical Treatment:

I voluntarily present for treatment and consent to treatment by an ApproXie health care provider. Such care may include, but is not limited to: laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that my treatment is intended to address weight loss with targeted medication along with physical activity and proper nutrition. No guarantee can be made to the results of treatments or examinations at ApproXie. Initials:________________

Notice of Privacy Practices:

I acknowledge review of ApproXie Health's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights. Initials:___________

Office Policy on Payment:

It is ApproXie's policy to require all payments to be made at the time of service. Our weight loss program offers a targeted prescription that requires different self-pay pricing depending on dosage. These visits will not be covered by insurance, and therefore will not run through your health insurance. If you are not sure you qualify for this medication, please read over the qualifications given to you before signing. NOTICE: pricing is subject to change at anytime. I have read this diclosure and agree with ApproXie Urgent Care's Office Policy on Payment. Initials:___________

Printed Name: __________________________ Date Signed: ______________________

Signature: ______________________________