ARIZE™ CLINIC
Maximize Your Weight Health Journey

General Information Form

(Please print legibly)

Date: _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address: _____

Primary Care Physician: _____ Phone Number:_____

Physician Address: _____

Emergency Contact: Name: _____Phone number: _____

Relationship: _____

How did you hear about this program? (Please mark all applicable boxes)

☐ Internet ☐ Magazine ☐ Newspaper ☐ Billboard ☐ Print Coupon ☐ Online Coupon

☐ TV ☐ WAFF 48 ☐ WHNT 19 ☐ WAAY 31 What TV Program? _____

☐ Facebook ☐ Twitter ☐ Pinterest ☐ Referral/Friend If so, who? _____

Occupation: _____ Employer: _____ Retired: ☐ Yes ☐ No

Current Weight: _____lbs. Goal Weight: _____lbs. Height_____

Please check and answer all that are applicable:

Do you use tobacco? ◯ Yes ◯ No Frequency_____ years of use_____

Do you use alcohol? ◯ Yes ◯ No Frequency_____ years of use_____

Do you use caffeine? ◯ Yes ◯ No Frequency_____ years of use_____

Do you drink sodas? ◯ Yes ◯ No Frequency_____years of use_____diet (y/n)____

Do you have regular bowel movements? ◯ Yes ◯ No How often?_____

Do you exercise? If so, how often? ◯ Yes ◯ No Frequency_____

Is your job stressful? ◯ Yes ◯ No Comments_____

Do you regularly get 7-8 hours of sleep? ◯ Yes ◯ No Comments_____

Prescribed Medications, Over- The- Counter Drugs, Dietary supplements

Name Strength Quantity / Dosage

_____
_____
_____
_____
_____
_____
_____
_____

Medical Conditions/Diseases: Please check all that are applicable.

- ☐ None
- ☐ High Cholesterol or Lipids
- ☐ High Blood Pressure (Ex: Hypertension)
- ☐ Lung Condition (Ex: Asthma, Emphysema, COPD)
- ☐ Ulcers (Stomach, Esophagus)
- ☐ Kidney Disease
- ☐ Gallbladder Disease
- ☐ Other (Please list below)
- ☐ Blood Clotting Problems
- ☐ Arthritis or Joint Problems
- ☐ Thyroid Disease
- ☐ Headaches/Migraines
- ☐ Hormone Related Issues
- ☐ Heart Disease
- ☐ Candida (carb cravings)
- ☐ Cancer
- ☐ Depression
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Constipation
- ☐ Diarrhea

_____
_____

Allergies: Please check all that apply.

1. ☐ Hypersensitivity to drugs/class/components of B12
2. ☐ Hypersensitivity to cobalt
3. ☐ Hereditary optic atrophy
4. ☐ Sulfa Drug
5. ☐ Dye Allergies
6. ☐ Codeine
7. ☐ Aspirin
8. ☐ Hypersensitivity to local anesthetics of the amide type
9. ☐ Nitrate Allergy
10. ☐ Morphine
11. ☐ Penicillin
12. ☐ Food Allergies (list)
13. ☐ Gluten Allergy/Intolerance
14. ☐ Lactose Allergy/Intolerance
15. ☐ Seasonal (pollen) Allergies
16. ☐ Other:_____

Doctor's use only:

I have personally reviewed medical history, medications and find no contradictions to program or products. _____

Dr. Dawn Mancuso

Notices

I hereby agree that I understand and have answered all the questions to the best of my ability. _____
Initial

I understand it is my responsibility to inform my Primary Care Physician of my current aesthetic treatment program. _____
Initial

General Consent for Evaluation and Treatment

You have the right, as a client, to be informed about the recommended programs and treatments to be used so that you may make the decision whether or not to undergo any suggested programs or treatments. At this point in your evaluation, no specific plan has been recommended. This consent is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate program or treatment for any identified goals. The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary examinations, testing, measurements and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after treatment is recommended and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your Primary Care Physician about the purpose, potential risks and benefits of any treatment program. You have the right to at any time to discontinue services, but you understand that all programs and treatments are non-refundable.

I voluntarily request an Arize Clinic consultant to perform reasonable and necessary examinations, testing, measurements and treatment for the condition which has brought me to seek care at Arize Clinic.

Client Signature: _____

Clients who have High Blood Pressure and/or Diabetes (Type 1 or Type 2)

I understand that my current medication was prescribed at my current weight and as my weight decreases my medications may need to be adjusted. _____
Initial

I agree to keep track of my blood pressure and/or blood sugar levels in my client journal and notify my primary care physician of my levels. _____
Initial

I understand that as I lose weight "fat" that I should postpone any blood lipid test (cholesterol) as my results will be inaccurate for 3-4 weeks after completing the program. _____
Initial

Clients who currently have or have previously been treated for a Sulfa Allergy

I understand that clients with an active or previously treated sulfa allergy are advised against receiving Arize Clinic MIC injections. I further acknowledge that I have fully disclosed any potential sulfa allergy, have consulted with my physician and have been made aware of the risks. I understand that voluntarily receiving Arize Clinic MIC or B12 injections could include side effects which might be hazardous to my health. I hereby release, discharge and hold harmless Arize Clinic and its affiliates, their employees and associated personnel against any liability, cost, loss, claims and actions, including negligence, based upon or sustained in connection with my voluntary participation in receiving Arize Clinic MIC or B12 injections.

Client Signature: _____

Female Clients

I understand that in the event I miss my period and a pregnancy test resulted in a positive. I will need to place my weight loss program on hold for 2-3 days and then retest for pregnancy. In the event of pregnancy, Arize Clinic requiress you immediately discontinue your weight loss program _____
Initial

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. *Images and/or recordings in which I am identified may be posted inside the clinic on the "before and after" success wall or in a picture frame inside clinic locations.* Images and/or recordings in which I am identified will not be released externally and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law. _____

Initial

Authorization and Consent of Parent(s) or Legal Guardian(s) for Minors:

I do hereby solemnly swear that I have legal custody of the aforementioned minor child. I grant my authorization and consent for _____ to be on The Arize Clinic Program. By signing this document I do confirm that I personally am responsible for monitoring my child throughout the length of The Arize Clinic Program. I understand that Arize Clinic is not responsible in any way for my child's participation, and that I am taking sole responsibility, as her Parent(s) or Legal Guardian(s), to ensure she/he is following the protocol to the specifications laid out in the client's journal that I have received and have reviewed with my health consultant. If at any point in time I see any medical concerns I will contact Arize Clinic immediately and I will be subject to removing my child from the program, if a Arize Clinic Medical Director or my child's Primary Care Physician sees fit.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Arize Clinic in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective as of this _____day of_____, 20 ____.

Parent(s) or Legal Guardian(s) Signature: _____

HIPPA Acknowledgement and Consent

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations other described and permitted uses and disclosures. I understand that I may contact the Privacy Director designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices. _____

Initial

Consent to Email or Text Usage for Appointment Reminders and other Communications

Clients may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team and to provide general reminders/information. If at any time, I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other communications/information at that email or text address.

I consent to receive text messages at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/information unless I request a change in writing. _____

Initial

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO THEIR CONTENTS.

Client Signature _____ **Date**_____

ARIZE™ CLINIC
Maximize Your Weight Health Journey

Injection Consent Form

(Please print legibly)

Date: _____

Review of General Information Form

I acknowledge that I have reviewed my client General Information Form, particularly the Medication, Medical Conditions and Allergies, and have either no changes noted or have updated my information. _____
Initial

Please check and answer all that are applicable

Hypersensitivity to drugs/class/components of B12?	◯ Yes	◯ No
Hypersensitivity to local anesthetics of the amide type?	◯ Yes	◯ No
Hypersensitivity to cobalt?	◯ Yes	◯ No
Hereditary optic atrophy?	◯ Yes	◯ No
Sulfa Allergy?	◯ Yes	◯ No

Acknowledgement and Consent

I acknowledge that injections will be intra-muscular. The injections will consist of B12 (B12) or a combination of B-12 and amino acids (MIC). These injections are not meant to treat, diagnose or cure any disease or illness. These substances may support weight loss, increase metabolism of fat and lead to an increase in energy.

I further acknowledge that there are risks associated with receiving any injection, including but not limited to:

- Bleeding
- Bruising
- Swelling
- Redness
- Pain
- Infection
- Allergic reaction to the injected substances

I understand that voluntarily receiving Arize Clinic MIC or B12 injections could include side effects which might be hazardous to my health. I hereby release, discharge and hold harmless Arize Clinic and its affiliates, their employees and associated personnel against any liability, cost, loss, claims and actions, including negligence, based upon or sustained in connection with my voluntary participation in receiving Arize Clinic MIC or B12 injections.

Client Signature _____ **Date**_____

Notice of Privacy Practices

Effective Date: December 3, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Director by dialing the main number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal consultant.

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to other facility personnel who are involved in taking care of you at the facility. Different personnel of the facility also may share health information about you in order to coordinate the different things you may need.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer.

For Clinic Operations: Members of the consultant staff and/or quality improvement team may use information in your record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all clients we serve. For example, we may combine health information about many clients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;

- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of consultants

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release information about you to a friend or family member who is involved in your care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at affiliated facilities as necessary to carry out treatment and payment operations. Consultants at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Privacy Director for further information on the specific sites included in this affiliated covered entity.

As required by law: We may disclose information when required to do so by law. As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply

additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

- **Inspect and Copy**: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend**: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Privacy Director. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures**: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
- **Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Privacy Director. We are required to agree to your request only if (1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and (2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice**: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please submit your request in writing to the Privacy Director.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Arize Privacy Director
400 Whitesport Drive SW
Suite 101
Huntsville, AL 35801
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