TRANSFORMATIONS CENTER OR WEIGHT LOSS, LLC.

GUIDELINES FOR WEIGHT MANAGEMENT PROGRAM

The undersigned agrees to follow the guidelines listed below

1. I will keep a **food diary or food journal as accurate as possible and bring with me every visit** otherwise Transformations center for weight loss health care provider(s) reserves the right to not prescribe medication for you.
2. I will lose at least **2-3 pounds** minimum if not more every visit
3. If you do not lose minimum weight for consecutive two-three visits then you will not be dispensed appetite suppressant
4. While you are taking appetite suppressant if Transformations center for weight loss Health care provider(s)notices untoward side effects, such as persistent rise in blood pressure, chest pain, or severe headaches, he or she will stop giving you the medication
5. If you do not lose **at least 10-15 pounds in 6 months**, Transformations center for weight loss health care provider(s) will not give you any more medication
6. You cannot take more than prescribed dose to lose faster and more weight
7. I will take this medication only to lose weight, not to maintain or feel good
8. Once you reach your desired weight loss goal, we will stop giving you the medication and transfer you to our weight maintenance program where we focus on behavioral modification, exercise, and diet only
9. You cannot share this medication with family members or friends either
10. If you gain weight while you are on this appetite suppressant, Transformations center for weight loss health care provider(s) will stop giving you the medication
11. You cannot take this medication with any other weight loss medication such as herbal supplements.

Transformations Center for Weight Loss, LLC
Patient Personal Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Height: _____ Current Weight: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

How were you referred to this office?:_____ Name: _____

MEDICAL AND WEIGHT INFORMATION

What do you consider the state of your overall health: ☐ Excellent ☐ Good ☐Average ☐ Poor

What was your Heaviest Weight:_____ How long ago: _____

WOMEN ONLY: **Last menstrual period:** _____ **Pregnant**: ☐ Yes ☐ No

Planning Pregnancy: ☐ Yes ☐ No **Nursing:** ☐ Yes ☐ No **Birth Control Method:**_____

Food or Drug Allergies: _____ Type of Reaction:_____

Medication History

Name	Dose	Frequency	How long on med.	Last took

Hospitalization and Surgical History

Date	Reason or Type of Surgery	Outcome

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Lipotropic (Lipo- B Complex) Injection information

LIPOTROPIC NUTRIENTS are compounds that promote the flow of fat & bile to and from the liver. In essence, they produce a "decongesting" effect on the liver and promote improved liver function and fat metabolism. Lipotropic substances decrease the deposit or speed up the removal of fat within the liver. Lipotropic mixtures combine liver and gallbladder therapies in one product and those using it can benefit simultaneously from the power and potential of them all.

Methionine, is one of the sulfur-containing amino acids (cysteine and cystine are others) and is important for many bodily functions. It acts as a lipotropic agent (others are inositol and choline) to prevent excess fat buildup in the liver and the body, is helpful in relieving or preventing fatigue, and may be useful in some cases of allergy because it reduces histamine release. Methionine works as an antioxidant (free radical deactivator) through conversion to L-cysteine to help neutralize toxins.

Inositol, a nutrient belonging to the B vitamin complex, is closely associated with choline. It aids in the metabolism of fats and helps reduce blood cholesterol. Inositol participates in the action of serotonin, a neurotransmitter known to control mood and appetite.

Choline, is considered one of the B-Complex vitamins as well as a lipotropic nutrient. It is present in the body of all living cells and functions with inositol as a basic constituent of lecithin. Choline appears to be associated with the utilization of fats and cholesterol in the body. It prevents fats from accumulating in the liver and facilitates the movement of fats into the cells. It is essential for the health of the liver and kidneys.

Pyridoxine or Vitamin B6, plays a vital role in metabolism by breaking down fats and carbohydrates for energy. The higher the protein intake the greater is the requirement of B6. Research shows that low levels of Vitamin B6 can lead to high levels of homocysteine which are associated with Heart attack, Alzheimer's disease, colon cancer, and hypertension.

Methylcobalamin, is a biologically active form of Vitamin B12. This means that your body can use it immediately without going through any metabolic steps to make it "body friendly". Methylcobalamin is considered the most potent form of Vitamin B12 found in nature and the only active form of Vitamin B-12 in the brain outside the mitochondria. We need methylcobalamin for the healthy development and sustenance of our circulatory, immune and nervous systems.

Chromium Picolinate "the blood sugar nutrient." Promotes normal insulin function. May help metabolize fat, turn protein into muscle and convert sugar into energy. It helps to overcome cravings and levels out the highs and lows associated with a high carbohydrate diet. Chromium supports the conversion of food to energy and increases metabolic rate.

I have been informed of the following regarding the injection:

- While all components generally have no side effects, doses must be taken at regular intervals. The injections are only effective temporarily.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people may experienced allergic reactions to the injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys. May cause frequent urination or diarrhea temporarily
- Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high.
- If any abnormal heart racing occurs, I will contact my medical provider immediately.
- I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

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Lipotropic (Lipo- B Complex) Injection Consent Form

Read and Sign Below:

Prior to injections being administered, I have thoroughly read the Lipo-B patient information and fully understand the above information about the Lipo B-Complex injection. I have had ample opportunity to read this information and have any and all questions regarding the Lipo B-Complex injection to be satisfactorily answered. I further acknowledge that I am taking this injection at my own risk.

I acknowledge, that I have carefully read the "side effects" and fully understand the instructions should an allergic reaction occur.

I relieve Transformations Center for Weight Loss` health care provider(s) and staff from any and all legal and medical liability from any side effect that may occur as a result of receiving the Lipo B-Complex injection.

I have read and understand all and have agreed to these statements.

Patients Name: _____

Signature: _____

Date: _____

1020 Edgewood Road, Edgewood, Md, 21040. Phone # 410 679 5755, Fax # 410 679 6613

14300 Cherry Lane Ct, #108, Laurel, Md, 20707. Phone # 301 725 4541, Fax # 301 725 4394

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PATIENT TREATMENT CONSENT FORM

I, THE UNDERSIGNED PATIENT :

A. I will use the medication as prescribed and directed by TCWL health care provider(s) and I will not abuse this medication
B. I will notify TCWL health care provider(s) of any side effects from the medications immediately.
C. I will notify TCWL health care provider(s) in case there are any changes in my medical condition including medications taken and any upcoming procedures or tests. If I do not, I agree not to hold TCWL health care provider(s) legally or medically responsible for the consequences that may arise from not doing so.
D. I have been told that lab tests are available to test kidney, liver, heart, and thyroid functions if so desired. I understand that I may choose not to have them or cannot afford to have them and still I can participate in the weight loss program offered but will not hold TCWL health care provider(s) responsible medically or legally for missing a diagnosis. There is a very small but definite chance of missing a medical problem if I do not have these tests done: **Kidney, liver, heart, thyroid and diabetes.**
E. **Circle and Initial** which tests you wish to perform, if you initial none then I accept full responsibility for not getting the tests done and you relieve TCWL health care provider(s),staff, and/or any of their affiliates from any and all medical and/or legal liability from any abnormality that might be missed by not ordering and performing these tests
F. I have been told by TCWL health care provider(s), while I am on this medication, I SHOULD NOT DRINK ALCOHOL OR USE ANY ILLEGAL OR NONMEDICAL PRESCRIPTION DRUGS.
G. Depending on my progress, I authorize TCWL health care provider(s) to keep me on the appetite suppressant medication shorter or longer than the recommended duration and more or less than the recommended dose based on the outcome of my weight loss. This will be based on my weight, goal and medical needs and may change at any given time.
H. I will not engage in obtaining prescription appetite suppressants illegally
I. I will not engage in obtaining prescription appetite suppressants for any other purpose but to lose weight
J. Have fully revealed any and all medical information as well as medicines that I am taking
K. I have been told by TCWL health care provider(s) that prescription appetite suppressants not be taken by persons with a history of drug and/or alcohol abuse or dependence. I will disclose such history so that prescription appetite suppressant be used feeling that benefits out-weigh the risks of abuse or addiction and will not hold TCWL health care provider(s) legally or medically responsible.
L. I have made aware by TCWL health care provider(s) that there is a risk of addiction to appetite suppressants and that in asking TCWL health care provider(s)to use these medications to help me lose weight. I relieve TCWL health care provider(s) from any and all legal and medical liability from any possible addiction that might occur.
M. I have been told by TCWL health care provider(s) that if I am a female, I should not get pregnant. If I do get pregnant while I am on this medication, I will not hold TCWL health care provider(s) legally or medically liable for any health problem for the me or my child.
N. I have been told by TCWL health care provider(s) that this medication is contraindicated in patient`s with blood pressure >150/100 but can be used in patients with controlled blood pressure (less than 150/100). If I have high blood pressure and requesting TCWL health care provider(s)to use these medications to help me lose weight, I relieve TCWL health care provider(s) from any and all medical and legal liability for any possible complications that might occur. I also agree to monitor blood pressure weekly and notify TCWL health care provider(s)if my blood pressure is greater than 150/100
O. I have been informed by TCWL health care provider(s) that I have a choice to request to stop taking the medication at anytime but continue with the weight management program using behavioral modification, exercise, and diet only.
P. I have read and understand all the information included in this patient consent form and that all my questions have been answered by the TCWL health care provider(s) to the best of their knowledge

Name: _____

Signature: _____ Date: _____

Transformations Center for Weight Loss, LLC.

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Maryland. This personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality care, implement payment activities, conduct normal practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. We will retain full ownership of all documentation collected, and reserves the right to duplicate it for treatment purposes. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including utilizing phone auto dialers to remind you of missed consults, follow-up to your diet, renewals, etc., voicemail/answering machine messages, postcards, newsletters and special events.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for used other than stated above. All such requests must be in writing. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Name: _____

Signature: _____ Date: _____

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