Modern MEDICINE

Patient Information Form

Patient name: (Last)_____ (First)_____ (MI)_____

Name you prefer to be called:_____

Birth date:_____ Age:_____ Sex: M F

Patient Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____

Email:_____

Employer:_____ Occupation:_____

In Case of Emergency:
Name:_____ Relationship:_____
Phone Number:_____

How did you hear about us: (*Please circle or identify where necessary)

Radio Friend Brochure TV Internet Direct Mail

If referred, by whom:_____

Financial Policy:

Thank you for selecting Dr. Michael Luft and his staff for your healthcare needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy; please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept Visa, MasterCard, Discover, HSA, FSA, and Cash. You are responsible for all costs associated with any services you obtain from our facility. I agree that if this account is referred to an agency or attorney for collection, I will be responsible for all collection costs, attorney fees and court costs.

The purchase of our weight loss program, lab tests, EKG and visit with physician/provider are non-refundable.

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

Patient Signature:_____ Date:_____

Patient Medical History Form

Patient Name:_____ Date of Birth:_____

1. Are you in good health? Yes No
   Explain a "no" answer:

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription Drugs:

Drug: Dosage: Reason:

1._____
2._____
3._____
4._____
5._____
6._____

Over-the counter Medications, Vitamins, Supplements:

Drug: Dosage: Reason:

1._____
2._____
3._____
4._____
5._____

Do you have any allergies to any medications? Yes No

Drug: Reaction:

1._____
2._____
3._____
4._____

Family History as it relates to obesity if applicable:

Father: _____
Mother: _____
Brothers/Sisters:_____

Are you allergic to Iodine? yes__ no__
Are you allegic to Shellfish? yes__ no__

Patient Name:_____ Date of Birth:_____

List any Serious Injuries with approximate dates:

_____

_____

Any Surgeries? (major surgeries only) Yes No

Specify with approximate date if yes:

Date: _____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

List all Hospitalizations (*with dates and reason for hospitalization):*

Date:_____ Reason:_____ Date:_____ Reason:_____

Date:_____ Reason:_____ Date:_____ Reason:_____

Date:_____ Reason:_____ Date:_____ Reason:_____

Patients Past Medical History:

___ Cancer: type_____	___ Thyroid Disorders	___ High Blood Pressure
___ Eating Disorders	___ Alcohol Abuse	___ Drug Abuse
___ Sleep Apnea	___Diabetes	___ Stroke
___ Polio	___ Measles	___Tonsillitis
___ Jaundice	___ Mumps	___ Pleurisy
___ Kidney Disease	___ Scarlet Fever	___ Liver Disease
___ Lung Disease	___ Whooping Cough	___ Chicken Pox
___ Rheumatic Fever	___ Bleeding Disorder	___ Mental Illness
___ Ulcers	___ Gout	___ Cardiac Arrhythmias
___ Anemia	___ Heart Disorder	___ Heart Disease
___ Tuberculosis	___ Gallbladder Disorder	___ Diabetes
___ Arthritis	___ Other: specify: _____	

Do You Smoke? Yes No

If yes: how many cigarettes daily?_____ How long have you smoked?_____

Do you drink alcohol? Yes No

How often do you drink?_____

How many drinks do you have when you drink on average?_____

Approximately how much caffeine do you consume on a typical day? _____

If female: *when was your last menstrual cycle?* _____

5362 South 72nd Street
Ralston, NE 68127
402-315-3600

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WEIGHT LOSS PROGRAM CONSENT FORM

I _____authorize Dr. Mike Luft and whomever they designate as their assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite sup___ pressant medication. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for a duration exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand there are certain health risks associated with remaining overweight or obesity. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack, heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form.

If you have any questions regarding the risks or hazards of the proposed treatment, or if you have any questions in general concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date:_____ Time:_____

Witness: _____ Patient: _____

(Or person with authority to consent for patient)

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PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

Procedures and Alternative

I, _____(patient or patient's guardian), authorize Dr. Mike Luft and whomever they designate as their assistant, to assist me in my weight reduction efforts. I understand my treatment may involve, but not limited to, the use of appetite suppressant for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

I have read and understand my doctor's statement as follows:

"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.

As a bariatric physician, I have found the appetite suppressant helpful for periods far in excess of 12 weeks and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggestions, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer terms studies, and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, increase doses.

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).

As a bariatric physician, I believe the probability of such side effects is outweighed by the benefits 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 the appetite suppressant use in this manner may give.

I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

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.

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 caloric counting program or an exchange eating program without the use of appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

_____ _____

Patient's Signature Date

HCG Diet Informed Consent to Treat

Purpose

This Informed Consent Form is intended to give fair notice of the requirements of patients seeking to participate in the HCG Diet Program at Modern Medicine, to fully disclose any risks associated with the participation in the HCG Diet program, and to obtain written "Informed Consent" from the patient to undergo treatment by health care professionals associated with the above stated clinics.

Clinical Applications

HCG was used in the treatment of obesity disorders by a British Doctor and PHD, A.T.W. Simeons. Dr. Simeons concluded that HCG ("Human Chorionic Gonadotrophic" Hormone) when used weight reduction and concurrent with a regimented protein diet, not only resulted in significant weight loss from targeted areas where fat deposits were likely to collect, but also improved the lipolytic functions of the body when co-utilized with dietary protein sources. Dr. Simeons theorized that by giving daily injections of small amounts of HCG concurrent with a high protein diet, that the HCG would mobilize the fat into the blood stream where protein and various enzymes could exercise their lipolytic functions (lipolytic means to break down fats usually for the consumption of energy). Dr. Simeons' clinic had a 97% success ratio. A number of medical authorities have since supported the theories advanced by Dr. Simeons. In "Medicine and Science In Sports and Exercise" (19:5 sec. 179-190, 1986), Dr. Layman, M.D. affirmed that the intake of high dietary protein: (1) aided in the metabolism of the free floating fat; (2) enhanced increased muscle mass; (3) preserved protein composition in the organs; (4) stabilized the blood glucose levels, and (5) enhanced the production of human growth hormone from the pituitary gland. Accord In J Am. Coll. Nutr. 2004 Dec: 23 (6:suppl): 631S-363S. Nevertheless in spite of these findings by specialized experts in the field of Preventative Health Care, the American FDA requires the following disclaimer:

> **"HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or 'normal' distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."**

Risks and Discomforts

Below is a list of risks and discomforts that may be experienced by a small part if the population, in particular, those patients that are already predisposed to allergies; the latter condition caused by a hyper stimulation of the hormone heparin within the body. The patient shall inform the primary health care provider if any of the following conditions occur:

Allergic responses

If you experience allergic reactions to other substrates, you may have sensitivity to HCG. It is required that you stop using HCG and report you allergic response to your physician immediately (emphasis added). The following are signs of an allergic reaction:

- Hives
- Difficulty breathing
- Swelling of your face, lips, tongue, and throat

Before receiving HCG tell your doctor if you are allergic to any of the following drugs or if you have:

- A thyroid or adrenal gland disorder
- An ovarian cyst
- Cancer or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland
- Undiagnosed uterine bleeding
- Heart disease
- Kidney disease
- Epilepsy
- Migraines, or asthma

It is necessary for the doctor to know these predisposed pathologies in order to rule out any symptomatology that may not be related to the HCG.

Also in allergic responses, the body overproduces fibrin which induces blood clotting, a potentially lethal situation. Call your doctor at once is you have any of these signs of a blood clot:

- Pain
- Warmth
- Redness

- Numbness it tingling in your arm or leg
- Confusion
- Extreme dizziness
- Severe headache
- Nausea or vomiting
- Urinating less than normal

Less Serious Side Effects May Include

Less serious side effects may occur from the change in dietary patterns, until the blood sugar levels stabilize over a period of time with the high protein intake. These less serious side effects include:

- Headache (diet related)
- Feeling restless or irritable
- Mild swelling or water weight gain
- Depression
- Breast tenderness or swelling
- Pain, swelling, or irritation where the injection is given

Breast Feeding

It is not known whether HCG passes into breast milk. Do not use HCG without telling your doctor if you are breast feeding a baby.

Other drugs may affect HCG

There may be other drugs that can interact with HCG. Tell your doctor about all prescription and over-the-counter medications you use. This includes vitamins, minerals, herbal products, and drugs prescribed by other doctors. Do not start using a new medication without telling your doctor.

Mandatory Adherence to Diet Protocol

To experience success on the clinic's HCG diet program, it is mandatory that you follow the diet protocol explicitly. We do not warrant the results of its diet program due largely to off-site administration and patient imposed application of the diet program.

Consent

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the weight loss treatment that includes the use of Human Chorionic Gonadptrophin (HCG) along with diet and other therapies with it associated risks. I have disclosed my full medical history and have been physically examined by my health care practitioner. I am aware of the significant or common risks, benefits, side effects and adverse reactions of HCG, and I have had full opportunity to ask any questions. I understand that HCG has not been approved by the United States Food and Drug Administration (FDA) for adjunctive therapy in the treatment of obesity and states that there is no substantial evidence that HCG increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie restricted diets. I hereby give consent to perform this and all subsequent Human Chorionic Gonadotrophin (HCG) treatments with the above treatments with the above understood. I hereby release the doctor, the person injecting HCG and the facility from liability associated with this procedure.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Time