

hCG SlimXpress™

1215 Regents Blvd. Suite B1 Tacoma, WA, 98466

Tel. 866-275-4424 – Fax: 253-564-9711

www.hcgslimxpress.com

New Patient Information

Personal Information

Last Name _____ M.I. _____ First Name _____

Birth Date _____

E Mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ (May we leave a message at this number? Y/N)

Alt Phone _____ (May we leave a message at this number? Y/N)

Occupation & hours per week _____

If you would like to receive e-mails from hCG SlimXpress™ about information on special saving on products or services or new services being offered please fill out the information below

Name (Please Print) _____

Cell Phone# _____ Home Phone# _____ Work Phone# _____

E-Mail Address _____

Medical Providers

Health care provider? _____

Phone: _____

Health Information

Primary Health concerns: _____

Past Hospitalizations: _____

Past Surgeries: _____

Current Medications: _____

Current Supplements/vitamins: _____

Allergies (foods/drugs/environmental): _____

Exercise (type & hours per week): _____

Do you smoke? Yes / No Packs/day _____ How many years of smoking? _____

Do you drink Caffeine? Yes / No

Nutrition / Diet

Do you follow a particular diet? _____

Have you gained/lost weight recently? Describe: _____

What are the names of weight loss programs or diets that you have tried?

Which type of diet was the most successful for you? _____

Please list foods you eat regularly for:

Breakfast _____

Lunch _____

Dinner _____

Amount of weight you would like to lose on the hCG SlimXpress™ Program _____
Are you aware that inch loss is one of the most important results of the hCG SlimXpress™ weight loss program? Yes No

Please Check All Conditions, Past or Present

Past Present		Past Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Spasms/Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	<input type="checkbox"/>	Rash /skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Stiff/Painful Joints	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica/Shooting pain
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Gas / Bloating	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Constipation / Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Allergies /Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	PMS /Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	TMJ or Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / seizures
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia

Family History- major health problems (cancer, cardiovascular disease, obesity, diabetes, osteoporosis, depression.)

Father _____

Mother _____

Siblings _____

The confidentiality, security and privacy of your personal health information is important to us. Please see our privacy statement for details. (enclosed)

By Signing below I state that I have fully read over and filled out the above health history questionnaire truthfully and accurately.

Signature _____

How did you hear or learn about our **hCG SlimXpress™** Program?

Referred by: Please circle one: Friend Family Member Workmate Other

Internet search: Please circle one: Google Yahoo MSN Facebook Twitter Other

None of the above

Do you know of anyone who has lost weight on the hCG SlimXpress™ program? Yes No

Have you read any of the book The Weight Loss Cure by Kevin Trudeau? Yes No

Are you aware that everyone you refer and books an appointment for the **hCG SlimXpress™** program, you receive a \$10 gift certificate which is good for any services and products at our clinic? Please circle: Yes No

SlimXpress™ Clinic

Informed Consent for Treatment

HCG is presently relied upon as a medication for fertility and it is also used to safely promote the production of testosterone in males. It is not approved by the FDA for weight loss.

I, _____, hereby authorize Dr. _____ physician contracted by Natural Health Technologies / SlimXpress™ to use the following to facilitate my diagnosis and treatment:

Common diagnostic procedures: (ex. blood draw, laboratory)

Use of nutrition: (Therapeutic nutrition, nutritional supplements and intramuscular vitamin injections)

Botanical medicine: (Teas, alcohol and glycerin extracts, solid extracts, capsules, tablets, creams, ointments and suppositories)

Prescription medications: (Antivirals, hCG, antibiotics, antifungal, hormonal, or other prescription medications)

Physical medicine: (Massage therapy, muscle energy stretching, trigger point release, manipulation, hydrotherapy, or similar hands-on therapies)

Lifestyle counseling and hygiene: (Diet therapy, promotion of wellness including recommendations for exercise, sleep and stress.)

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: Restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipunctures or procedures, tenderness/soreness or bruising from physical treatments.

Side Effects: The HCG side effects to keep an eye out for include the onset of headaches, irritability, restlessness, slight water retention, tenderness of breast tissue, swelling of the injection site, and depression. There are some rare, severe side effects as well which include the development of ovarian hyper stimulation in females. The latter condition requires immediate medical treatment and is accompanied by the following symptoms: tremendous pain in the region of the pelvis, the swelling of feet, legs, and hands, abdominal pain, abdominal swelling, difficulty breathing, diarrhea, vomiting, nausea, a diminishing of urination, and weight gain. If a user of HCG products notes any side effects it is recommended that he or she cease using the products immediately and that he or she seek out the assistance of a physician.

Notice to all pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential, and will not be released to others unless so directed by myself, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by my paying the appropriate fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment. I understand that the doctor will answer any questions that I might have.

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the doctor nor any personnel of Natural Health Technologies / SlimXpress™ has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement.

Print Name _____

Signature _____ Date _____

Signature of Patient Representative or Guardian _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Natural Health Technologies/ SlimXpress™. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Natural Health Technologies / SlimXpress™ reserves the right to change the privacy practices that are describes in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. (*Please circle*)

ANY MEMBER OF THE IMMEDIATE FAMILY	Y / N	_____
SPOUSE:	Y / N	_____
OTHER (please Specify)	Y / N	_____

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Statement of Privacy Practices- hCG SlimXpress™

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 Washington. 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, ECT. Natural Health Technologies retains 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 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. We may charge you for copies in an amount allowed by law. 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 of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Date _____

hCG SlimXpress™ Prescription Agreement Form

Because your health can vary over time, hCG SlimXpress™ only honors prescriptions for three (3) months after the prescription is written. After three (3) months another consultation with our doctor is required.

I have read and understand the aforementioned statement.

Signature

Date

HCG is given by prescription only. If I discontinue the hCG SlimXpress™ program for any reason, I understand that my initial prescription is valid for three (3) months from the time the prescription is written. If there is no discontinuation of the program, the initial prescription is also only valid for three (3) months.

I have read and understand the aforementioned statement.

Signature

Date

Cardholder Agreement No Refund/Cancellation Policy

I understand that I will pay for my sessions at the time service is rendered. I understand that hCG SlimXpress™ is a 'cash practice'; therefore, my insurance will not necessarily cover any procedure or payment toward any of my sessions. I agree to cancel/or reschedule my sessions at least **48 hours** in advance of existing scheduled appointments by calling or leaving a detailed message to hCG SlimXpress™ @ 253.564.9223.

Upon calling the receptionist or calling and leaving a message, I will leave detailed information including time and date I called and the time and date of my canceled appointment. If I fail to do so or do not show up for my session, I understand hCG SlimXpress™ will charge the credit card number listed below the full service charge fee. I understand that there is a full service charge fee of all appointments no showed or canceled less than 48 hours in advance. This includes all nutritional, spa appointments and any other types of booking made at hCG SlimXpress™.

I have read this disclosure in detail and I understand the terms and refund/cancellation policy.

Print Name _____

Sign Name _____

Valid Credit Card # _____ Exp. Date ____/____

Visa Mastercard Discover American Express

Name on Credit Card _____

This form must be fully complete with your required credit card information in order for us to move ahead so that you are able to receive your scheduled session. All credit cards will be verified but not charged unless you do not comply with the above refund/cancellation policy. If you change credit cards and the cardholder information is no longer current; it is necessary that you provide updated information to the receptionist at hCG SlimXpress™.

We look forward in seeing you as a client/patient of hCG SlimXpress™.

The Following Disclaimer is required by the FDA:

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. The FDA has not approved hCG for weight loss.

Print Name _____

Sign Name _____

Date _____