ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Total Approach Wellness and Aesthetics
200 Forsythe Street
Fayetteville, NC 28303
Office: (910) 322-7368
Fax: (910) 483-5796
www.TAWellness.net

I, _____ have read (available at the practices website)
(Name of Patient)

Total Approach Wellness and Aesthetics' "Notice of Privacy Practice".

_____
(Signature of Patient or Guardian)

Staff Will Fill Out This Section if Patient's Signature is Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature

_____ Language barrier kept us from obtaining the patient's signature

_____ Other: _____

_____

Total Approach
Wellness and Aesthetics

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HCG DIET QUESTIONNAIRE

Date Completed _____ / _____ / _____

First Name: _____ Middle Initial: ____ Last Name: _____

Please complete the General Medical History form in addition to this page.

1. How many years have you been struggling with your weight? _____ yrs
2. What is the highest weight you have reached? _____ lbs
3. What efforts have you tried to lose weight?

   ☐ Medications ☐ Exercise and diet ☐ Online programs

   ☐ Weight loss centers Which ones? _____

   ☐ Other methods Explain: _____
4. Were any of these successful? ☐ Yes ☐ No How much weight did you lose? _____ lbs
5. Why do you think you put your weight back on?
6. How much did you regain? _____ lbs
7. Do you snack between meals? ☐ Yes ☐ No
8. Do you often fail to complete projects you start? ☐ Yes ☐ No

CONSENT FOR HCG TREATMENT

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The Nature of Treatment

I hereby give my consent to evaluate and treat obesity, and the overweight condition by the administration of HCG (Human chorionic gonadotrophin) and nutritional supplements, including vitamins, minerals and anti-oxidants designed to aide in the reduction of abnormal fat. The nature of this procedure is to raise levels of HCG in my body to levels which will aide in the loss of abnormal fat and preserve structural and visceral fat. By normalizing weight this will improve my quality of life, functional ability and decrease incidence of sickness and disease. Regarding the nutritional supplements, the goal is to raise levels of vitamins, minerals and anti-oxidants in order to maximize the physiologic processes in my body and minimize damage by naturally produced free radicals.

The General Nature and Extent of Treatment-Related Risks

The overweight condition and obesity have unwanted potential for illness when this condition goes untreated. Along with my provider, I believe weight loss is an important part of treatment and prevention of diseases such as high cholesterol, diabetes, hypertension and joint pain exacerbated by stress on all systems in the body. By obtaining the ideal body weight I will reduce my potential for these diseases and help decrease the symptoms due to obesity.

Although I am aware this is not an FDA approved treatment, I understand there have been many clinical applications of HCG and weight loss that have had potential for weight loss from 15-30 pounds in 30 days.

The potential for adverse side effects are constipation, failure to lose weight due to dietary errors, pain from uterine fibroids due to weight loss, Gallstones, problems with receding gums and tooth loss in prolonged use, increased risk of alcohol intoxication with small amounts of alcohol and painful heel due to subcutaneous fat loss. Patients that have recently had heart attack or stroke, pregnancy, or have had a past medical history of anorexia or bulimia or have an active case of tuberculosis or Diabetes Type I may not participate in this program.

I understand I will have the choice of injectable form of HCG or the sublingual form of HCG. I also understand the clinical studies have been done with injectable forms of HCG and show potential for the most weight lost and reduced hunger on a VLCD (very low calorie diet). Some patients have had equal success with sub lingual forms of HCG.

HCG is thought to work by using abnormal fat while on a VLCD. It is not a sex hormone. It works the same in women as it does in men. It is thought to work in a part of the brain that regulates and maintains the central nervous system which controls all autonomic functions such as breathing, heart rate, digestion and sleep. Therefore, it is thought to control the operation of storing and issuing fuel in the body in the form of fat and sugar.

In patients with diabetes, weight loss will bring about lower blood sugars therefore I understand if I am diabetic I will agree to check blood sugar twice daily and inform my provider immediately so my medication can be adjusted to decrease risk of hypoglycemia.

While taking HCG patients with arthritis may experience relief of joint pain. I understand once treatment is stopped my symptoms may return.

It has been demonstrated in patients with high cholesterol their levels may rise initially with weight loss but with continued loss of weight cholesterol will decrease. This is a well-known phenomenon often seen in weight loss due to the release of cholesterol deposits that have not yet undergone calcification in the arterial wall. This is a beneficial effect.

If I have gout I may expect an acute rise in the blood uric acid levels. I may expect an acute attack after the first few days of HCG treatment and then remain pain free during the rest of the treatment cycle. If I repeat the cycle I may again experience an acute gout attack. After treatment, I can expect decreased episodes of pain from gout. I may be given Zyloric if I have a history of gout to avoid attacks during treatment.

I understand I may experience a drop in blood pressure while on HCG. I will monitor my blood pressure carefully and if I do not have a way to do this at home will consent to monitoring weekly at this clinic. It may be necessary to decrease my blood pressure medication while on HCG treatment and return to previous medication once HCG is stopped.

Safety of HCG Administration for Weight Loss

Although in my physician's opinion, the majority of data points toward safety, no one has yet proven or has yet disproved a causal relationship between the use of HCG therapy and weight loss. I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. These methods can only be used in The Center for Health and Restoration.

I understand there are other studies that show HCG is ineffective as a weight loss treatment. However, studies like these, which show an association (two variables present simultaneously), do not demonstrate cause and effect. I realize that it may be several years before we know if there is any true cause and effect between HCG and weight loss.

I also understand there are possible benefits associated with these procedures. I understand that no guarantee has been made to me regarding outcomes neither of this treatment nor on resolution of my symptoms. I understand that not all patients receive the same degree of response. I also understand that the benefits derived from therapy will cease and those derived from HCG therapy and drugs that alter hormone levels may not reverse if the therapy is discontinued.

I also understand that if I am female and become pregnant, I will stop the entire treatment protocol immediately and notify my physician. I understand that this therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

I understand that HCG has been approved by the FDA for use in the treatment of certain diseases. I also understand that the FDA only approves or disapproves of products made by manufacturers which are produced in an established dosage and form. Therefore by definition, the FDA does not "approve" or "disapprove" of HCG which are given in an individual dose and in an appropriate form for each patient as determined by my doctor at The Center for Health and Restoration. I also understand that my doctor may choose to discuss with me and provide to me medications that are off-label in order to offer to me the widest range of therapies possible. ("Off-label" use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them.) "Off-label" prescribing is a legal and common practice by physicians in the United States.

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones prescribed to me. I will conform and comply with the recommended dose and methods of administration. I also agree to conform to the request for initial and subsequent blood tests, as required. I understand that failure on my part to follow my physician's recommendations in dosage and use of HCG and medication may result in unwanted and potentially harmful problems. I understand that failure to have appropriate laboratory testing done at the interval established by my physician and failure to follow up with my physician at the recommended appointments may lead also to adverse (unwanted) side effects.

I authorize my physician to perform this treatment. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my care. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of the procedure.

I hereby confirm that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental because they are not aimed at treating a disease, and there are no long-term studies documenting the results. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

To attest to my consent to this treatment, I hereby affix my signature to this authorization to treatment.

Patient Name (please print above)	Witness Name (please print above)
Signature of Patient (please sign above)	Signature of Witness (please sign above)

GENERAL MEDICAL HISTORY

Total Approach Wellness and Aesthetics
200 Forsythe Street
Fayetteville, NC 28303
Office: (910) 322-7368
Fax: (910) 483-5796
www.TAWellness.net

➢ *Demographics:*

Date Completed _____ / _____ / _____

First Name: _____ Middle Initial: ____ Last Name: _____

➢ *Chief Goal:*

Briefly explain why it is you came to this practice:

➢ *Past Medical History:*

Please check any medical conditions or health problems that you currently have or have had in the past.

Condition	*Now*		*Past*		*Condition*	*Now*		*Past*	
Ankle swelling	❍		❍		Hepatitis/Liver disease	❍		❍	
Anxiety or excess. stress	❍		❍		Herniated Disc	❍		❍	
Artificial joint/implants	❍		❍		High Blood Pressure	❍		❍	
Asthma	❍		❍		High Triglycerides	❍		❍	
Bleeding disorder	❍		❍		Irregular Heart Beat	❍		❍	
Blood Clotting problems	❍		❍		Kidney disease / Stones	❍		❍	
Cancer	❍		❍		Fibrocystic Breasts	❍		❍	
Carpal Tunnel Synd.	❍		❍		Lung or breathing problems	❍		❍	
Chest Pain	❍		❍		Osteoarthritis	❍		❍	
Chronic bronchitis	❍		❍		Osteoporosis/Osteopenia	❍		❍	
Chronic Indigestion	❍		❍		Psoriasis or eczema	❍		❍	
Constipation/diarrhea	❍		❍		Psych. or Emotional Illness	❍		❍	
Depression	❍		❍		Rectal Bleeding	❍		❍	
Diabetes	❍		❍		Rheumatoid Arthritis	❍		❍	
Fibroid uterus	❍		❍		Seasonal allergies	❍		❍	
Fibromyalgia	❍		❍		Seizures Disorder	❍		❍	
Gallbladder disease	❍		❍		Skin problems/dermatitis	❍		❍	
Glaucoma	❍		❍		Stomach Ulcers	❍		❍	
Headaches	❍		❍		Stroke/vascular disease	❍		❍	
Heart Disease	❍		❍		Thyroid disease	❍		❍	
Heel Pain	❍		❍		Tuberculosis	❍		❍	

➢ ***Past Medical History (cont):***

Any significant birth-related events?

Any significant/traumatic injuries?

➢ ***Family History*:**

Do you have a family member (mother, father, grandparents or sibling) with any of the following?
Abbreviations: MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather. If positive, indicate the age in the box at which onset occurred.

						Grandparents			
	Condition	**Mother**	**Father**	**Sister**	**Brother**	**MGM**	**MGF**	**PGM**	**PGF**
☐	Breast Cancer								
☐	Prostate Cancer								
☐	Uterine Cancer								
☐	Ovarian Cancer								
☐	Colon Cancer								
☐	Fibrocystic breast								
☐	Heart Disease/stroke								
☐	High Cholesterol								
☐	Diabetes								
☐	High Blood Pressure								
☐	Osteoporosis/ Osteopenia								
☐	Alzheimer's disease								
☐	Psychiatric illness								

➢ ***Social History:***

Do you use tobacco? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what is your occupation? _____
Is the job stressful? ☐ Yes ☐ No
Is your job physically demanding? ☐ Yes ☐ No

Education:
☐ High school/GED ☐ College ☐ Post-Graduate

Martial Status:
☐ Single ☐ Divorced ☐ Married/Partnered

Do you have any children? ☐ Yes ☐ No
If so, kindly provide their gender and their ages: _____

Do they live with you? ☐ Yes ☐ No

➢ ***Surgical History:***

Please list all surgeries that you have had since birth. Include the year.

Surgery	**Year**

➢ ***Previous Studies/Tests:***

Have you had any of the following tests performed?

Yes	No	Test	If yes, what was the month/yr?	Result	
				Normal	Abnormal
☐	☐	Mammography			
☐	☐	PAP Smear			
☐	☐	Uterine Ultrasound			
☐	☐	Bone Density			
☐	☐	Colonoscopy			
☐	☐	Cardiac Testing Type:			

➢ ***Dietary and Exercise History:***

Do you do exercises?	☐ Yes	☐ No
Do you do weight resistant exercises? (Lift weights)	☐ Yes	☐ No
Do you do aerobic exercises?	☐ Yes	☐ No
Do you practice yoga?	☐ Yes	☐ No

I eat at fast-food restaurants _____ times per week.

I consume:

- ☐ Coffee ____ cups per day
- ☐ Regular soft drinks _____ cans/btls per day
- ☐ Diet soda _____ cans/btls per day
- ☐ Energy drinks _____ cans/btls per day
- ☐ Alcoholic beverages _____ per day
- ☐ Water _____ oz. per day

Servings of the following per day:

Meat	_____
Vegetables	_____
Fruit	_____
Nuts	_____
Dairy/Cheese	_____
Bread	_____
Candy/sweets	_____

Do you snack between meals?

What are your favorite snack foods?

➢ ***Prescription Medications – Prescribed by a Physician:***

This includes any medication or therapy prescribed by a physician.

	Medication	**Strength: units in mgs, gms, IU, mcg**	**At what times do you take this medication?**	**Year Started.**	**Are you currently taking this medication?**
1					
2					
3					
4					
5					
6					
7					
8					

Vitamins and Over-the-Counter (OTC) Products:

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

➢ ***Allergies:***

☐ No known allergies to medications

Antibiotics	☐ Penicillin	☐ Sulfa	☐ Other antibiotics:
Prescription Medication:	☐ Morphine	☐ Codeine	☐ Aspirin
Environmental Allergies:	☐ Seasonal	☐ Pets	☐ Ragweed, pollen, grasses
Food Allergies:	☐ _____	☐ _____	☐ _____ ☐ _____
Chemical Sensitivities:	☐ Dyes	☐ _____	☐ _____

Any other allergy not noted above?: (please list):

Please describe the reaction to the allergen listed above. Was it life-threatening?

Describe the extent to which you are exposed to chemicals or metals.

Any Mercury Fillings? ☐ Yes ☐ No

➢ ***Physician Information:***

☐ **No Primary Care Physician** ☐ **No Specialist**

Primary Care Physician
Name: _____

Specialist Physician
Name: _____

Total Approach Wellness and Aesthetics

Patient Demographics:

Last Name: First Name: MI:

DOB: Gender: SSN:

Marital Status: Employ. Status Prof. Title:

Addr Line 1: Addr Line 2:

City: State: Zip:

Home Phone: Work Phone: Work Ext:

Cell Phone: Fax: Email:

Employment Information:

Employ. Name Employ. Phone

Addr Line 1: Addr Line 2:

Employer City: State: Zip:

Emergency Contact:

Contact Name: Relationship to Patient:

Addr Line 1: Addr Line 2:

City: State: Zip:

Home Phone: Cell Phone:

Primary Insurance:

Insurance Co. Name:

Primary Insured: Last Name: First Name: MI:

DOB: SSN of Primary

Patient Relationship To Primary Insured:

Subscriber ID: Group No: Plan Name:

Secondary Insurance:

Insurance Co. Name:

Secondary Insured: Last Name: First Name: MI:

DOB: SSN of Secondary

Patient Relationship To Secondary Insured:

Subscriber ID: Group No: Plan Name:

Guarantor Information: (if different from primary insured or patient)

Guarantor: Last Name: First Name: MI:

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OFFICE POLICIES

1. There is a **cancellation fee** for patients who do not cancel their appointment prior to a full 48 hours. **As a safeguard**, **please email your cancellation in writing to avoid any confusion regarding the cancellation deadline**. If you fail to do so, your credit card will be charged for the missed appointment on the day of the appointment. **For new patient appointments, the cancellation fee is $350.00. You will be billed according to our office fee schedule for the missed appointment.** Please call as soon as possible to let us know if you cannot keep your appointment. In order to provide better service to our patients we do not overbook to compensate for no shows therefore we must bill for missed appointments.

2. If you are late for an appointment you will be seen for the remainder of your appointment time only in order to avoid delays for other patients. There will be no adjustment in the charge for the visit.

3. If you go over your scheduled appointment time, and there is no other patient scheduled, you will be charged on a prorated basis for the additional time spent with the provider. Please be sure to review our office fee schedule.

4. There is a cost for copying medical records plus postage. In accordance with Title 45, Section 164.524© of the Code of Federal Regulations, there is a cost related to medical records retrieval, certification and copying. You must sign our medical release form and pay the copying fees before records are sent. Medical records are sent within 3 weeks of a completed request. All outstanding bills must be paid in full before medical records are sent.

5. Prescription refill request should be done during appointment times or on-line only. **Prescription refills** are called in within 48 hours of their request. Patients who have not been seen recently may be required to come in for an office visit before a prescription is called in. A fee of $10.00 for prescriptions requested over the phone or needed prior to 48 hours may apply.

6. Insurance companies may not cover prescriptions called in to the compounding pharmacy; therefore the compounding pharmacy will call you directly for a method of payment prior to shipping it to you.

7. All lab results are reviewed and discussed during appointment times. Results can only be given over the phone during a phone consultation with the doctor. The charge for the phone consult will depend on the amount of time required for the consult.

8. Medical questions should be addressed during appointment times. Our staff may handle brief questions but in-depth questions will require an appointment with the doctor.

9. The doctors are available for phone consultations for the convenience of our patients who live out of town or have schedules which do not permit them to come in for office visits. If you request to speak with the doctor by phone for any reason your account will be billed accordingly. Please allow our staff to handle simple questions and requests, to avoid a physician's fee. **You will be billed for all phone calls or emails that require time from the physician according to our fee schedule.**

10. **All services and product sales are final**. Patients are responsible for payments for services and labs performed. No refund will be given once a service has been provided or lab test has been performed. There are no refunds on products sold in our office for any reason. Please do not ask the staff or doctor for refunds once you have purchased a product.

11. Patients who show up for unscheduled appointments to speak with the doctor will be billed according to our fee schedule if the doctor is available. You will be billed for the amount of time that you speak with the physicians even if you do not have an appointment. Please be considerate of other patients who have appointments so that the office can run smoothly and efficiently and schedule an appointment.

12. We require a credit card to be on file for patients in the event that products, lab kits, etc. have to be sent to patients, and for appointment and cancellation fees. Patients who request credit card **charge backs** for any reason will be billed **$150.00 per charge back** in addition to the original charges for services provided by our office. All fees are due at the time of services. Patients are responsible for all fees incurred by Total Approach Wellness and Aesthetics for collections. Credit card charge backs will be immediately turned over for collections at the expense of the patient.

13. We do not provide disability forms for patients who desire disability coverage. Your primary care physicians must complete these forms.

14. Our office specializes in functional medicine, and stress, hormone, and health lifestyle programs. **We do not assume the responsibility for treatment of major medical illnesses that you are currently being treated for by your primary physicians.** Please continue treatment with your primary care physician or OB/GYN for routine medical problems.

15. Patients please call the office before coming to the office to pick up supplements, tests, etc., to avoid delaying appointments for patients on the schedule for that day and to allow us to prepare for your needs. Please be patient with our staff until patients with appointments have been assisted.

16. We reserve the right to immediately discharge a patient from our practice if a patient is abusive to the staff or refuses to honor our office policy.

17. Our office policy is designed to provide structure for our office so that we provide good consumer service and ensure that all patients receive the same quality service and treatment. We strive to make your experience a good one and welcome your helpful feedback.

18. If you are dissatisfied for any reason, please alert our office and we will make every effort to correct the problem and accommodate your needs.

Thank you for choosing Total Approach Wellness and Aesthetics to provide your medical needs. Your business is greatly appreciated.

By signing below you acknowledge that you have read this document and agree to abide by our office policies and fee schedule. Please initial each section of the office policy.

_____
Patient's Name (Please Print)

_____
Patient's Signature

_____
Date

CREDIT CARD AUTHORIZATION

Total Approach Wellness and Aesthetics
200 Forsythe Street
Fayetteville, NC 28303
Office: (910) 322-7368
Fax: (910) 483-5796
www.TAWellness.net

I, (please print name)________________________________, authorize Total Approach Wellness and Aesthetics to charge my credit card for the following reasons: Office Visits, Mail Orders/Products, Phone Consultations, Cancellation Fees, and Procedure Deposits.

____
Patient Signature

____
Date

Note:
Information is provided for credit card with the last four digits ________, expiring ________.
The provided information is to be removed from the patient file and stored in a secure location.

Cut ➔ >>>

Credit Card Authorization

>>>
>

Patient Name: _______________________________ Date: ____________
(Print)

Patient Signature: ____

Credit Card: Visa / MasterCard / American Express

Card Number: ____

Card Expiration: ______________ Security Code: _______________

Information is to be used only as specified on the Credit Card Authorization Form.

CONFLICT RESOLUTION AGREEMENT

Total Approach Wellness and Aesthetics
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Fax: (910) 483-5796
www.TAWellness.net

This contract is between Total Approach Wellness and Aesthetics, hereafter referred to as "TAWA" and _____, hereafter referred to as "Patient." This contract establishes an agreement for TAWA to provide certain medical services to the Patient ("Agreement"). The terms of this agreement are detailed below:

COVERED MEDICAL SERVICES:

TAWA agrees to provide the medical services as indicated below. The medical services are designed to incorporate metabolic and nutritional medicine for the Patient to analyze lifestyle, environmental considerations, and prevention of disease.

_____ Metabolic and Nutritional Medicine

_____ Weight Management

_____ Nutritional Supplements

_____ Bio-Identical Hormones

_____ Wellness Testing

_____ Functional Medicine

_____ Mental Health

MEDICAL SERVICES EXCLUDED:

TAWA does not prescribe any medicine that requires a prescription from a medical doctor with the exception of hormones and occasional other compounded medications. Instead, the medical services provided are therapeutic products designed to aid with disease prevention and overall wellness. TAWA shall not provide criticize or consult Patient in regards to the medical advice prescribed by a provider other than TAWA. In addition, TAWA shall not provide medical advice in regards to any medications prescribed by a medical provider other than TAWA. At no time should any medical services, advice, or pharmaceuticals provided by TAWA be construed by the Patient as an alternative or substitution for medical advice or prescriptions given by any other medical providers of the Patient. Instead, any medical services, advice provided, or pharmaceuticals prescribed by TAWA shall be viewed and utilized as a supplement to medical advice or prescriptions given by any other medical providers of the Patient.

COSTS FOR SERVICES:

The costs for services provided under this Agreement are subject to separate agreements between the parties. The consideration for this Agreement, the receipt and sufficiency of which are both hereby acknowledged, are the medical services provided herein.

CONFLICT RESOLUTION:

For the consideration and services provided for herein, receipt of which is acknowledged by the parties, any controversy or claim arising out of or relating to this Agreement, or its breach, shall be settled by arbitration in Cumberland County, North Carolina in accordance with the Commercial Rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. If any legal action or arbitration based in contract is necessary to enforce or interpret the terms of this Agreement, the prevailing party will be entitled to reasonable attorneys' fees and costs in addition to any other relief to which that party may be entitled. The parties to this Agreement hereby expressly waive any right they may otherwise have to a trial by jury in the Twelfth Judicial District, Cumberland County, North Carolina.

IN TESTIMONY WHEREOF, the parties hereto have set their hands and seals this the ____ day of _____, 20__.

PATIENT

_____

_____

WITNESS