Eugene F. Guerre Jr., M.D.

Genesis Weight Loss Center

Our program is built upon the 3 elements of success. They are diet & nutrition, medication & supplements, and exercise & hydration.

If any one of the components is not followed or utilized the likelihood of success decreases.

The efforts to overcome being overweight or obese are not easy. It may take you more than once to make the lifestyle changes necessary to end the struggle against your weight and adopt a healthy lifestyle.

We realize how difficult it can be and it is nothing to be embarrassed about. By restarting the program you are already taking the right steps to find success. Our hope for you on this occasion is that you make the right adjustments to solidify that success for the long term.

During your consultation with the restart consultant and the physician, you will find that they are going educate you on the new program and how we will help you to succeed. They are also going to review your previous records to make the necessary changes that will help you succeed in losing the weight and guide you in the long term maintenance.

The medical staff will also evaluate your health risks. Many of your risks may still be present or have worsened. Your body composition is a major component in many of these health risks. Other factors that will contribute to increased risks are genetics, nutrition, lifestyle, and a lack of supplements. The treatment plan you receive today will review these risks and recommend a plan to reduce these risks.

We hope that you chose Eugene F. Guerre Jr., MD Genesis Weight Loss Center not only for your weight loss needs, but also for our medical expertise in providing you with treatment options to increase your overall health and Wellness.

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Patient Information (Please Print)

FIRST NAME	LAST NAME

DATE OF BIRTH	AGE	GENDER	
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	

EMERGENCY CONTACT (Last Name, First Name)	PHONE NUMBER

Supporting you in your journey of weight loss and maintenance is very important to us. Therefore, from time to time, we may wish to send you information, samples or special offers that we may feel may be of interest to regarding Eugene F. Guerre Jr., MD Genesis Weight Loss Center and/or Zone Wellness. We may also contact you in relation to consumer research, marketing and customer surveys. If you would rather not receive additional information and/or offers, please do not check the box below.

PRIVACY: Your information will be kept strictly confidential and not provided to any third parties.

☐ **Yes, I would like to receive such information & offers by postal mail**
☐ **Yes, I would like to receive such information & offers by phone**
☐ **Yes, I would like to receive such information & offers by email**

How did you learn about the program?	
☐ Patient Referral	☐ Newspaper (Please Identify):
☐ Magazine (Please Identify):	☐ Television (Please Identify):
☐ Other (Please Describe):	☐ Internet

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Weight History

NAME	DATE

Height:	Current Weight:	What is your desired weight:

How long has it been since you were last on the program?

What has been your heaviest weight since you were last on the program?

Did you make it to your desired weight when you were last on the program? ☐ Yes ☐ No

If not, why do you feel you were unsuccessful?

What is the biggest struggle you face in trying to lose & maintain your weight?

Are any members of your household overweight? ☐ Yes ☐ No

If yes, please list relation and details...

What is your motivation for returning to our weight loss & wellness program?
Check all that apply.

☐ Don't like the way I look	☐ Clothes don't fit anymore	☐ Increase self confidence
☐ More energy	☐ Improve health	☐ Lower blood pressure
☐ Better work opportunities	☐ Feel better	☐ Look & feel younger
☐ More mobility	☐ Want to wear smaller sizes	☐ Control blood sugar
☐ Attend a wedding/graduation	☐ Detoxify the body	levels
☐ Reduce Pain	☐ Look better	☐ Reduce medications
☐ Perform better	☐ Live longer	☐ other (please describe):

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Medical History

Family History (If blood relative has suffered the following, please indicate relationship.)			
Heart Attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

Have you ever been hospitalized? If yes, when and why?	
Year	**Illness or Operation**

Medications (Please list the medications you are currently taking, and as needed.)			
Medication	**Dosage**	**How Often**	**Reason**

Allergies (Please list any medications or food that you are allergic to.)

Medical History								
Yes	**No**		**Yes**	**No**		**Yes**	**No**	
		Loss of hearing			Stomach ulcers			Immune disorders
		Ringing in ears			Hemorrhoids			Alcohol abuse
		Ear infections			Hernia			Drug abuse
		Bad vision			Gall bladder			Hypertension
		Glaucoma			Sudden weight loss			Heart disease
		Nose bleeds			Liver disease			Other eating disorders
		Sinus trouble			Back pain			Frequent urination
		Sore throat			Diarrhea			Kidney disease
		Allergies			Constipation			Prostate disease
		Hoarseness			Bloody/tarry stools			Headaches
		Pneumonia			Joint pain			Fatigue
		Bronchitis			Broken bones			Thyroid disease
		Asthma			Dizzy spells			Cancer
		Short of breath			Fainting spells			Diabetes
		Tuberculosis			Memory loss			Stroke
		Heart murmur			Insomnia			Osteoporosis
		Palpitations			Nervousness			GERD
		Irregular pulse			Depression			Rashes
		Swollen ankles			Phobias			Chicken pox
		Chest pain			Manic depressive			Mumps/measles
		Loss of appetite			Anxiety			Polio
		Indigestion			Anemia			Are you pregnant?

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Supplements (Please list the supplements you are currently taking, i.e. vitamins, fish oil, etc...)			
Supplement & Brand Name	**Dosage**	**How Often**	**Reason**

Wellness Goals

Which of the following supplements, or products, would you like to incorporate into your wellness Plan?
Check all that apply.

☐ Cardiovascular System	☐ Immune System	☐ Hormone Therapy
☐ Joints	☐ Depression	☐ Weight Maintenance
☐ Bones	☐ Digestive System	☐ Health Related Foods
☐ Prostate	☐ Sexual Activity	☐ DNA Testing
☐ Cognitive System (Mind)	☐ Detoxifying the body	☐ Anti-Aging
☐ Weight Loss	☐ Hair Loss	☐ Testosterone Levels
☐ Beauty/Hair/Skin	☐ Menopause	☐ other (please describe):

Do you feel like your health is improving or declining?

If you could take steps to improve your health for the long term, would you? ☐ Yes ☐ No

What is your #1 health concern?

What changes to your current health are the least important to you?

If you could change one thing today about your weight or wellness what would it be?

Do you have others in your family who have wellness concerns as well? ☐ Yes ☐ No
If yes, please list relation and details...

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Appetite Suppressant and Weight Loss Consent

I hereby authorize Dr. Guerre and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise program, ZONE Wellness, and lifestyle changes. I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. Appetite suppressants labeling suggestions are based on short-term studies of 12 weeks. The experience of Bariatric physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements and injections are effective for longer than 12 weeks.

Dr. Guerre and associates believe in the off label use of medications proven to be effective in medical studies to promote weight loss and in the use of nutritional supplements and injections. These injections, nutritional supplements and medications can help you lose weight faster and make you feel better while you are losing weight. These nutritional supplements, injections and medications can boost your energy, burn fat faster, and eliminate cravings. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise or and eat fewer calories. Dr. Guerre and associates disagree with this simplistic thinking, and believes that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

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

In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heart beat, and heart irregularities. Less common, but more serious risks are valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that there are risks associated with obesity. Among these risks are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, hips, knees, and feet. I also understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop significant gallbladder disease during their lifetime. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible.

There is no guarantee that the program will work for me. By consenting to treatment I agree to pay in full for all visits and charges at the time of each visit. **I understand that your services are not reimbursed by insurance, and that you do not provide or fill out claim forms for insurance purposes.** I understand that no refunds are ever given at any

time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience; however, I may request that a prescription be written for the weekly dose of the medication.

I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Eugene F. Guerre Jr., M.D. or this office's physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications.

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

My signature further confirms that I do not have a current history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. My signature also confirms that if I have a past history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, I have fully disclosed this information in my medial history, since these conditions constitute a contraindication to the use of appetite suppressants.

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By signing below I certify that I have read and fully understand this consent form. **I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction.**

I further understand that Eugene F. Guerre Jr., MD Genesis Weight Loss Center and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

My signature below indicates my consent of treatment.

Patient: _____ Date: _____

Witness: _____

Physician Declaration

I have explained the contents of this document to the patient and have answered all the patient's related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient had consented to therapy involving the appetite suppressants.

Physician's Signature: _____ Date: _____

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Photographs Consent Form

I DO _____, DO NOT _____ (Please initial one) hereby authorize Eugene F. Guerre Jr., MD Genesis Weight Loss Center staff to take my fully clothed photograph during my initial consultation, during, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and are kept in my chart at all times.

I DO _____, DO NOT _____ (Please initial one) give permission for my photographs to be used by Eugene F. Guerre Jr., MD Genesis Weight Loss Center for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

Patient: _____ Date: _____

Witness: _____ Date: _____

For office use only

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form
&
Authorization for the use of Disclosure of Individually Identifiable Health Information to Business Associates of Eugene F. Guerre Jr., M.D.

I, _____ , have received a copy
Patient Name

of Dr. Guerre's Genesis Weight Loss Center's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

I hereby authorize the use or disclosure of my individually identifiable health information as described in the referenced Notice of Privacy Practice. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations (HIPAA) or State law. This authorization expires three (3) years from the date set forth below.

_____ _____
Signature of Patient Date

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Patient authorization for disclosure of protected health information

I, _____, D.O.B. _____,

SS# _____, authorize Dr. Guerre and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name: _____

Name: _____

Name: _____

Name: _____

_____ _____

Signature Date

_____ _____

Witness Date