Health Profile

Date: _____/_____/_____/

Dietary consultation involves a health profile. The purpose of the health profile is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on his or her health profile.

1. General:

(Please use print characters)

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip/Postal Code: _____

Phone: _____ Cell: _____ Email: _____@_____

Date of Birth: _____/_____/_____/**Age:** _____* Profession: _____

Who may we thank for referring you?_____

Current Weight: _____ lbs. Height: _____ Weight 1 year ago: _____ lbs.

Minimum adult weight: _____lbs. at age _____ Maximum adult weight: _____ lbs.

Do you exercise? ☐ Yes ☐ No If yes, what kind? _____

How often? ☐ Daily ☐ Weekly ☐ Other: _____

Have you been on a diet before? ☐ Yes ☐ No If yes, please specify which diet(s) and why you think it didn't work for you (e.g. too rigid, too much cooking involved, etc.):_____

_____

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's professionally supervised weight loss method: (circle one)

Least important **1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** **Very/Most Important**

What is your marital status? M S D W Other Do you have children? ☐ Yes ☐ No

How many children do you have? _____ How old are your children? _____

Who does most of the cooking in your house? _____

On average, how many hours do you sleep per night? _____

Who is your primary care physician (family doctor)? _____

Physician List:
Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

2. Diabetes:

Do you have diabetes? ☐ Yes ☐ No (If not, please skip to next section)

Which type?

a. ☐ **Type I** **- Insulin-dependent (insulin injections only)**

b. ☐ Type II - Non-insulin-dependent (diabetic pills)

c. ☐ Type II - Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored ☐ Yes ☐ No If so, how often? _____

If so, by whom? ☐ Myself ☐ Physician ☐ Other (Please specify): _____

Do you tend to be hypoglycemic? ☐Yes ☐ No

3. Cardiovascular Function:

Have you had any of the following cardiovascular conditions?

a. ☐ Heart Attack (NPC)
b. ☐ Blood Clot (NPA)
c. ☐ Pulmonary Embolism (NPA)
d. ☐ Stroke or TIA (NPA)
e. ☐ Coronary Artery Disease (NPA)
f. ☐ Heart Valve Problem (NPA)
g. ☐ Heart Valve Replacement – porcine / mechanical (NPA)
h. ☐ Arrhythmia (NPA - if on Rx medications)
i. ☐ Hypertension (High blood pressure) (NPA)
j. ☐ Hyperlipidemia (High cholesterol/triglycerides)
k. ☐ Hypokalemia (Low Potassium) (NPA)
l. ☐ Hyperkalemia (High Potassium) (NPA)
m. ☐ Congestive Heart Failure (NPC) -

Please select one (if applicable):

☐ History of Congestive Heart Failure
☐ Current Congestive Heart Failure (NPC)

Have you ever had ANY type of heart surgery? ☐ Yes ☐ No

If so, which type? _____

Other conditions: _____

If you have answered yes to any of these conditions, please give dates of occurrence. For multiple conditions, please specify:

_____ _____
_____ _____
_____ _____

4. Kidney Function:

Have you had:
a. Kidney Stones ☐ Yes ☐ No Date: ____/____/ c. Kidney Disease (NPA) ☐ Yes ☐ No Date: ____/____/
b. Kidney Transplant (NPA) ☐ Yes ☐ No

d. Do you have Gout? ☐ Yes ☐ No If so, since when? ___/___/

If so, what medication has been prescribed? _____

If no, have you ever had Gout? ☐ Yes ☐ No If so, when? ____/____/

If yes to any of these events, please give dates of events. For multiple events please specify:

_____ _____
_____ _____
_____ _____

5. Liver Function:

a. Have you had any liver issues? (NPA) ☐ Yes ☐ No Date: ____/____/

If yes, please list:

_____ _____

_____ _____

6. Colon Function:

Do you have:

a. Irritable Bowel Syndrome	☐ Yes ☐ No	d. Ulcerative Colitis	☐ Yes ☐ No
b. Diverticulitis	☐ Yes ☐ No	e. Crohn's Disease	☐ Yes ☐ No
c. Constipation	☐ Yes ☐ No	f. Diarrhea	☐ Yes ☐ No

If yes to any of these events, please give dates of events. For multiple events please specify:

_____ _____

_____ _____

_____ _____

7. Digestive Function:

Do you have:

a. Acid Reflux	☐ Yes ☐ No	**e. Gastric Ulcer (NPA)**	**☐ Yes ☐ No**
b. Heartburn	☐ Yes ☐ No	f. Celiac Disease	☐ Yes ☐ No
c. Are you Gluten intolerant?	☐ Yes ☐ No		

d. History of Bariatric Surgery (NPA) ☐ Yes ☐ No

If so, what type of bariatric surgery? _____

8. Ovarian/Breast Function:

Please check the situations that apply to you currently:

a. Irregular Periods	☐ Yes ☐ No	e. Menopause	☐ Yes ☐ No
b. Fibrocystic Breasts	☐ Yes ☐ No	f. Painful Periods	☐ Yes ☐ No
c. Hysterectomy	☐ Yes ☐ No	g. Heavy Periods	☐ Yes ☐ No
d. Amenorrhea	☐ Yes ☐ No	h. Uterine Fibroma	☐ Yes ☐ No

Date of last menstrual cycle: ____/____/____/

Are you on oral birth control pills? ☐ Yes ☐ No

i. Are you pregnant? ☐ Yes ☐ No j. Are you breastfeeding? ☐ Yes ☐ No

9. Endocrine Function:

a .Do you have thyroid problems? ☐ Yes ☐ No If so, please specify: _____

b. Do you have parathyroid problems? ☐ Yes ☐ No If so, please specify: _____

c. Do you have adrenal gland problems? ☐ Yes ☐ No If so, please specify: _____

Have you been told you have Metabolic Syndrome (also called "Syndrome X")? ☐ Yes ☐ No

10. Neurological/Emotional Function:

Do any of the following apply to you?

a. Bipolar Disorder	☐ Yes ☐ No	f. Panic Attacks	☐ Yes ☐ No
b. Parkinson's disease	☐ Yes ☐ No	g. Anorexia (History of)	☐ Yes ☐ No
c. Epilepsy (NPA)	☐ Yes ☐ No	h. Bulimia (History of)	☐ Yes ☐ No
d. Alzheimer's disease	☐ Yes ☐ No	i. Schizophrenia	☐ Yes ☐ No
e. Depression	☐ Yes ☐ No	j. Anxiety	☐ Yes ☐ No

Other issues: _____

11. Inflammatory Conditions:

Do any of the following apply to you?

a.☐ Migraines d. ☐ Fibromyalgia f. ☐ Rheumatoid g. ☐ Lupus

b.☐ Psoriasis e. ☐ Chronic Fatigue Syndrome h. ☐ Multiple Sclerosis i. ☐ Osteoarthritis

c.☐ Other autoimmune or inflammatory condition

12. Cancer:

a. Do you have Cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

b. Have you ever had Cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

When was the Cancer diagnosed? ____/____/____/

c. Is your Cancer in remission? (NPC) ☐ Yes ☐ No

If so, how long have you been in remission? _____ (mo/yrs)

13. General:

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify:

_____ _____

_____ _____

14. Allergies:

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please list:

_____ _____

_____ _____

15. Eating Habits

(Please be as honest as possible so that we may better help you)

Breakfast

Do you have breakfast every morning? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Do you have a **snack** before lunch? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Lunch

Do you have lunch every day? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Do you have a **snack** before dinner? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Dinner

Do you have dinner every day? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Do you have a **snack** at night? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Are you a vegan? ☐ **Yes** ☐ **No**

(Strict Vegans do not qualify due to too many dietary restrictions)

Are you a vegetarian? ☐ Yes ☐ No

How many glasses of water do you drink per day? _____ glasses per day

How many cups of coffee do you drink per day? _____ cups per day

Do you smoke? ☐ Yes ☐ No

If so, packs per day _____ for how many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often?

_____

16. Medications

Dear Client: Please complete this form by listing all prescription medications and supplements that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet? *	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500 mg	1	1 x a day	Dr. John Doe	Omega 3

* or grams, mEq or dosage unit your doctor prescribes.

CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES

I confirm that the information that I have provided and that is recorded by me on this Ideal Protein[tm] Health Profile is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that I do not have any of the **conditions** and that I am not taking any of the **medications specifically highlighted in purple or blue / underlined / identified as NPC or NPA on this form.** Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein[tm] Weight Loss Method if I have any of the said conditions or if I am currently talking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on the Ideal Protein[tm] Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein[tm] Weight Loss Method, and iii) and provide documentation confirming the foregoing.

I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to the clinic and iii) nevertheless chose to go on the Ideal Protein[tm] Weight Loss Method without specific supervision, such decision will be completely voluntary, and I release and discharge the clinic as well as Ideal Protein of America Inc., its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releasees**") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision.

I confirm that the Ideal Protein[tm] Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein[tm] Weight Loss Method, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein[tm] Weight Loss Method as explained to me verbally and in the materials provided to me, both before and during the period I will be following the Ideal Protein[tm] Weight Loss Method.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein[tm] Weight Loss Method limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein[tm] Weight Loss Method.

I undertake to disclose immediately to the clinic any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am on the Ideal Protein[tm] Weight Loss Method.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules and guidelines of the American Arbitration Association, and I waive any rights to pursue any claims or causes of action in any court of law.

SIGNED IN _____ (City/State), on this ____ day of _____, 2013

Witness:

_____ (Signed)
Name of client (print):_____

_____ (Signed)
Name of witness:_____

Last Name: _____ First Name: _____ DOB: ____/____/____/

_____ Initials

PRO-CARE MEDICAL CENTER
ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR DIRECT PAYMENT

Assignment of Benefits, Assignment of Rights to Pursue ERISA and other Legal and Administrative Claims associated with my Health Insurance and/or Health Benefit Plan (Including Breach of Fiduciary Duty), Designation of Authorized Representative and Authorization for Direct Payment

I hereby assign and convey directly to Pro-Care Medical Center (also doing business as Injury Medical Group and Injury Diagnostic Services), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Pro-Care Medical Center (hereinafter refers to Pro-Care Medical Center, Injury Medical Group and Injury Diagnostic Services), regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Pro-Care Medical Center to release all medical information necessary to process my claims. Further, I hereby authorized my plan administrator fiduciary, insurer, and /or attorney to release to Pro-Care Medical Center any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Pro-Care Medical Center or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits, plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Pro-Care Medical Center (including any right to pursue those legal or administrative claims or chose in action). This constitutes and express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Pro-Care Medical Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Pro-Care Medical Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Pro-Care Medical Center) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Pro-Care Medical Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment of valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

> **PERSONAL INJURY PATIENTS ONLY:** I hereby direct any and all party's insurance companies to make direct payment to Pro-Care Medical Center for all services, items and/or supplies furnished to me or my family members for and in relation to my care at Pro-Care Medical Center. I am choosing to forgo the use of my own health insurance, if any health insurance is available, in order to preserve my healthcare benefits. I am requesting that all of my medical bills are billed solely to the responsible 3rd party insurer, UIM and/or PIP. My health insurance may only be billed at the sole discretion of Pro-Care Medical Center.
>
> **Personal Injury Patient Initials: _____**

Patient's Printed Name | Date of Birth

Patient/Legal Representative Signature | Date

Relationship to Patient

Pro-Care Medical Center

Consent for Treatment, Notice of Privacy Practices Policy, and Financial Policy

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Pro-Care Medical Center unless revoked by me orally or in writing. I understand that the practice uses audio recording of patient encounters and unrecorded live video feeds of rehabilitation treatment from time-to-time solely for educational and training purposes within the practice and I consent to audio recording and unrecorded live video of my patient encounters for this purpose.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Pro-Care Medical Center's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Pro-Care Medical Center if any of these situations occur during your treatment period.

Consent To Treatment Of A Minor Child *(Under the age of 18)*
I authorize this office to administer services as deemed necessary to my minor child, _____. My relation to the minor child is _____.

A **Notice of Privacy Practices (NPP)** is available to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, has access to a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

As a part of our professional relationship, it is important that you have an understanding of our financial policy.

- It is your responsibility to provide us with your most current insurance and billing information.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (512) 371-7478 or (210) 881-0630.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

We may charge you a fee if you fail to attend, cancel, or reschedule your appointment with less than one full business day's notice. Cancellation fees are $40 for MD/DO/FNP appointments, $20 for DC/Ideal Protein appointments, and $200 for any specialist/procedures.

My signature below indicates that I have read and fully understand the Consent for Treatment, Privacy Practices Policy, and Financial Policy.

Patient's Printed Name _____ Date of Birth _____

Patient/Legal Representative Signature _____ Representative Relationship _____ Date _____

Pro-Care Medical Center

Assignment of Benefits and Authorization for Direct Payment

Assignment of Benefits, Assignment of Rights to Pursue ERISA and other Legal and Administrative Claims associated with my Health Insurance and/or Health Benefit Plan (Including Breach of Fiduciary Duty), Designation of Authorized Representative and Authorization for Direct Payment

I hereby assign and convey directly to Pro-Care Medical Center (also doing business as Injury Medical Group and Injury Diagnostic Services), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Pro-Care Medical Center (hereinafter refers to Pro-Care Medical Center, Injury Medical Group and Injury Diagnostic Services), regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Pro-Care Medical Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and /or attorney to release to Pro-Care Medical Center any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Pro-Care Medical Center or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits, plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Pro-Care Medical Center (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Pro-Care Medical Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Pro-Care Medical Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Pro-Care Medical Center) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Pro-Care Medical Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

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Patient's Printed Name Date of Birth

Patient/Legal Representative Signature Representative Relationship Date