# Dareld R. Morris II, D.O.

Morris Medical Weight Loss Program

Dear Patient,

We would like to welcome you to our office. Our medically supervised program will provide you with the foundation to accomplish your weight loss goals quickly and safely. The first phase is the Acute Weight Loss Step, which lasts until your desired weight loss is attained. The second phase is the Transitional Step during which you will be medically guided, and introduced to Zone Wellness. The third phase is the Long-Term Maintenance Step, in which we will provide you with the support you need to remain at your goal weight, and live the Zone way of life.

Your program begins with a consultation with a member of our medical staff. During this time you will be instructed on our nutritional plan which is proven to lower your blood insulin level. This process increases the body's ability to burn fat, and creates the foundation of maintaining your weight loss. A comprehensive blood panel, an EKG, and your weight and body fat index measurement will be performed. You will also be provided with a basic exercise regimen, which is a very important component to a successful weight loss program.

Our physician will then evaluate your medical and weight history, and make the appropriate recommendations for your individualized program. You will be prescribed and dispensed a Food and Drug Administration (FDA) approved appetite suppressant, which has been proven to be safe and effective for many years. Our program also utilizes weekly supplementary injections that will enhance your desired weight loss outcome.

Our program requires weekly scheduled visits to assess your progress, dispense your medication, and make any indicated changes. We take great pride in our program, and thank you for your interest.

Kind Regards,

Dr. Morris and Staff

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## Patient Information (Please Print)

| FIRST NAME | LAST NAME |
|---|---|
| | |

| DATE OF BIRTH | AGE | GENDER | SOCIAL SECURITY # |
|---|---|---|---|
| | | ☐ 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 Morris Medical Weight Loss Program 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 |
| ☐ Magazine | ☐ Television |
| ☐ Other (Please Describe): | |

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## Weight History

| NAME | DATE |
|---|---|
| | |

| Height: | Current Weight: | What is your goal weight: |
|---|---|---|
| How long have you been trying to lose? | | |
| What has been your heaviest weight? | | |
| When were you that weight? (record your age) | | |
| When did you first become overweight? | | |
| What do you think is the cause of your weight problem? | | |
| Have you ever stayed the same weight for ten (10) years or more? ☐ Yes ☐ No | | |
| Are any members of your household overweight? ☐ Yes ☐ No<br>If yes, please list relation and details… | | |

**What was your motivation for weight loss before joining our program?**
Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Perform better
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller sizes
- ☐ Upcoming vacation
- ☐ Look better
- ☐ Live longer
- ☐ Feel more confident socially
- ☐ Look more attractive for my partner
- ☐ Reduce medications
- ☐ Want to wear more stylish clothing
- ☐ Upcoming anniversary/birthday
- ☐ other (please describe):

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In order to assist you in achieving your weight loss goal, please check the programs that you have previously participated in. Please list under comments if you were successful in obtaining your goal, and if not why the program did not meet your expectations.

| Name of Program | Results? | Why this program fell short of you expectations… |
|---|---|---|
| ☐ Weight Watchers | ______ | ______ |
| ☐ Jenny Craig | ______ | ______ |
| ☐ Slim Fast | ______ | ______ |
| ☐ Atkins | ______ | ______ |
| ☐ South Beach | ______ | ______ |
| ☐ L A Weight Loss | ______ | ______ |
| ☐ Nutri System | ______ | ______ |
| ☐ Lindora | ______ | ______ |
| ☐ Other | ______ | ______ |

**Do you exercise? If so, how often do you exercise?**

☐ Never ☐ Rarely ☐ Daily ☐ 4-5 times a week ☐ 2-3 times weekly ☐ once a week

**What is your exercise routine?**
Check all that apply.

- ☐ Walking
- ☐ Swimming
- ☐ Dancing
- ☐ Aerobics
- ☐ Pilates
- ☐ Stairmaster
- ☐ other (please describe):
- ☐ Bicycling
- ☐ Yoga
- ☐ Sports (basketball, tennis, etc.)
- ☐ Strength training
- ☐ Elliptical
- ☐ Treadmill / Jogging

______________________________

______________________________

# Dareld R. Morris II, D.O.

Morris Medical Weight Loss Program

## 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 you are allergic to.) |
|---|
| |
| |

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

## Appetite Suppressant and Weight Loss Consent

I hereby authorize Morris Medical Weight Loss Program 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.

Morris Medical Weight Loss Program 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. Morris Medical Weight Loss Program 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. These and other risks could, on occasion, be serious.

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.

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.** My signature further confirms that I do not have a 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. I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Morris Medical Weight Loss Program 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.

I further understand that Morris Medical Weight Loss Program 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: ______________________________

## Photographs Consent Form

I hereby authorize Morris Medical Center staff to take my 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 Morris Medical Weight Loss Program for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

**Signature: _________________________________** **Date: __________________**

**Witness: _________________________________** **Date: __________________**

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For office use only

# Receipt of Notice of Privacy Practices

## Written Acknowledgement Form

I, ____________________, have received a copy of Morris Medical Weight Loss Program's
Patient Name

Morris Medical Weight Loss Program's Notice of Privacy Practices.

______________________________ ________________
Signature of Patient Date

## Patient authorization for disclosure of protected health information

I, ________________________________________, D.O.B. ______________________,

SS# _________________________, authorize Morris Medical Weight Loss Program 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

# Dareld R. Morris II, D.O.

## Morris Medical Weight Loss Program

**NOTICE OF PRIVACY PRACTICE**
**Effective Date: April 14, 2003**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO This INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**

**OUR OBLIGATIONS:**

**We are Required By Law To:**

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of out notice that is currently in effect

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:** Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer. (See Overleaf)

***Treatment:*** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example: we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in our medical care and need the information to provide you with medical care.

***Payment:*** We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

***Health and Care Operations:*** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have another relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services:*** We may use and disclose Health Information to contact your medical care or payment for your care, such as your family or a close friend. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care:*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research:*** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research projector for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:** ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state, or local law.

***To Avert a Serious Threat to Health or Safety*****:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates:*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation:*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissue to facilitate organ, eye or tissue donations, and transplantation.

***Military and Veterans:*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers Compensation:*** we may release Health Information for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness.

***Public Health Risks:*** We may disclose Health Information for public Health activities. These activities generally include disclosures to prevent or control disease, injury, or disability, report births and deaths; report child abuse or neglect, report reactions to medications or problems with products; notify people of recalls of products that they may be using; inform a person who may have been exposed to a disease or may be at risk

fro contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

***Health Oversight Activities:*** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

***Lawsuits and Disputes:*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement:*** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

***Coroners, Medical Examiners, and Funeral Directors:*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

***National Security and Intelligence Activities:*** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

***Protective Services for the President and Others:*** We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of State, or to conduct special investigations.

***Inmates or Individuals in Custody:*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or health and safety of others, or 3) for the safety and security of the correctional institution.

**YOUR RIGHTS:** You **have the following rights regarding Health Information we have about you:**

***Right to Inspect and Copy:*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **See Below.**

***Right to Amend:*** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to S**ee Below.**

***Right to an Accounting of Disclosures:*** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **See Below.**

***Right to Request Restrictions:*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that we not share information about particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **See Below**. ***We are not required to agree to your request***. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Right to Request Confidential Communication:*** You have the right to request that we communicate with you about medical manners in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to **See Below**. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact, **See Below**. All complaints must be made in writing. You will not be penalized for filing a complaint.

**PRIVACY OFFICER'S ADDRESS AND PHONE NUMBER:**

Kelly Morris
(239) 418-0775
2621 Cleveland Ave.
Fort Myers, FL 33901 U.S.A.