hCG Weight Loss Atlanta

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Patient Intake Form

Today's Date: _____

Patient information:

Name: (Last)_____(First)_____(MI)_____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____Email Address: _____
Birthdate:_____Age:_____Weight:_____Height:_____Sex: ☐ Male ☐ Female
How did you hear about us? ☐ Internet- words searched: _____
☐ Referral - Name: _____ ☐ Other: _____

Emergency Contact:

Name: _____Relationship: _____ Phone:_____

Payment:

How do you plan to render payment for your services today? (please check all that apply)
☐ Credit Card ☐ Cash ☐ Check ☐ HSA ☐ FSA
Will you be paying in full or scheduling a payment plan (43-day program only)? _____

Medical Information: (Please check if you have had any of the following):

☐ Cancer, type:	☐ Itching	☐ Arthritis	☐ Hypothyroidism
☐ Diabetes, type:	☐ Eczema	☐ Joint Pains	☐ Hyperthyroidism
☐ Headaches/Migraines	☐ Hives	☐ Colitis/Crohns	☐ Anemia
☐ Lung Disease	☐ Heart Disease	☐ Kidney Disease	Male:
☐ Asthma	☐ Chest Pains	☐ Kidney Stones	☐ Enlarged Prostate
☐ Anxiety	☐ Palpitations/fluttering	☐ Gallbladder Disease	☐ Low Testosterone
☐ Depression	☐ High Blood Pressure	☐ Gallstones	☐ Prostate Cancer
☐ Insomnia	☐ Swelling of feet/ankles	☐ Liver Disease	☐

Date of last physical examination _____ Reason:_____
Hospitalizations _____ Dates _____ Reason:_____

Current Medications (including OTC medicines): _____
_____
Allergies (medicines, foods, etc.)_____
Is there any possibility you could be pregnant (Females)? _____
Have you had any of the following: Blood clots, ovarian or breast cancer? _____
How many days per week do you currently exercise? _____

Menstrual History:

Menstruation began at age:_____28-day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____Date of 1st day of last menstrual period:_____
Amount of flow: Light ____ Med. ____Heavy_____
Date of last mammogram: _____Are you on birth control? (Method): _____

Initials:_____ I authorize hCG Weight Loss Center to leave my lab results on my voicemail.

Financial Policy:
Thank you for selecting hCG Weight Loss Center, Inc. for your weight loss needs. We are honored to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. This is to inform you of our installment billing requirements and our financial policy. Installment billing is for services rendered, this is not, a recurring charge or subscription payment.

I understand a minimum payment of $200, plus any lab fees incurred, are due on the date of my initial exam and program orientation. If I am not approved for the pharmaceutical hCG program my only cost will be $100, which will cover the cost of my office visit and meeting with the healthcare professional.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

_____ _____
Patient's Signature Date

REFUND POLICY: Once the treatment is started, we cannot honor any refund requests based on scheduling conflicts, missed doses, unsatisfactory results, other conflicting medical opinions, other health problems that might concurrently arise, or any other reasons.

I have read and understand all of the above. I fully understand what I am signing and hereby request and consent to Anti-Aging/weight-loss treatment using injections of HCG.

_____ _____
Patient's Signature Date