Client Information Sheet

Blissful Wellness
MEDICAL WEIGHT LOSS CENTERS

Referral Source (√)

_Friend/Family (Name: _____)
_Co-worker (Name: _____)
_Newspaper (Paper name: _____)
_Mint Magazine _____
_Money Pages Magazine _____
_Radio (Station name: _____)
_Television (Station name: _____)

_Internet Search
_Billboard (Loc_____)
_Email
_Mailing
_Other:_____

_Drive By
_Physician
_Event_____
_Brochure/Pamphlet/Flyer

General Information

Name: _____ Date:_____

Date of Birth:_____Current Age:_____Marital Status: S M D W Other: _____

Address: _____ Home Phone: _____

City: _____ Cell Phone:_____

State: _____ Zip Code:_____ Email: _____

Occupation: _____ Work Phone:_____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Are you a former client? Yes No If, Yes, which location?:_____

Date of last visit:_____

Appointment Information

Were you informed to fast? (not eat 6 hours prior to appointment) . . . . . Yes No

Were you informed of the expected duration of your appointment today? . . . . . Yes No

Do we have permission to communicate your progress with your primary care physician? . . . . . Yes No

Primary Care Physician Name _____

Address _____ Phone _____

City/State_____Fax _____

_____
Client Name PRINTED

_____
Date

_____
Client Signature

Reviewed By: _____
Physician Signature

Dietary, Weight & Exercise History

How much did you weigh at this time last year? _____

Which best describes the eating philosophy of your pare ts?

Eat until you are no longer hungry Eat until you are full Clean your plate

What best finishes the statement "My refrigerator and pantry are full of . . ." *(circle all that apply)*

1. Fruit, nuts, water, yogurt, sugarless snacks, sugarless drinks, low fat milk
2. Chips, candy, soda, cake, mayonnaise, whole milk
3. A combination of 1 and 2

Have you ever had an eating disorder? Yes No If Yes, what type: _____

_____

What medications or supplements have you taken in the past in an attempt to lose weight? *(please list all)*

_____

_____

_____

What other diets have you tried in the past? Tell us about your experience(s).

Diet: Date(s): Weight Loss/Experience:

_____

_____

_____

_____

_____

_____

How many hours of TV do you watch each week? _____

What types of exercise do you currently do and how often?

Exercise: Frequency:

_____

_____

_____

_____

_____

Activity Level *(pick one)*

_____Inactive - no regular physical activity
_____Light - usually during leisure time
_____Moderate - occasional activity on weekend
_____Heavy - lifting, stair climbing, sports 3 times a week
_____Vigorous - extensive exercise for 60 min. 4 times a week

What condition, situation, factors and/or behavior (e.g. pregnancy, stress induced eating, night time snacking, etc...) contributed to your weight gain?_____

_____

Do you feel out of control while eating? Yes No If so, which foods?_____

_____

If you have lost weight, and then regained, please indicate the 3 most important reasons for the weight gain:

___less exercise ___stress ___socializing ___other(s) _____

___infrequent clinic visits ___stopped weight checks ___depression _____

___lack of support ___overeating at meals ___lack of planning _____

What do you find is the most difficult about managing your weight? _____

_____

What do you believe will be of the most help to assist you in losing weight? _____

_____

How confident are you that you can lose weight this time? Confident 4 3 2 Not confident

How much support can your friends provide? Support 4 3 2 No support

How much support can your family provide? Support 4 3 2 No support

Do you follow a special diet? ___No ___Low Fat ___Vegetarian
___Diabetic ___Low Sodium ___Kosher
___Other *(please specify)*:

_____

Which meals do you normally eat? ___Breakfast ___Brunch ___Lunch ___Dinner

When do you usually snack? ___Morning ___Afternoon ___Evening ___Late Night ___Throughout day ___Never

What are your common snack foods? _____

_____

Do you usually eat out or order food in? Yes No How Often? ___Daily ___Weekly ___Monthly ___Other

How is your food usually prepared? (pick all that apply) ___Baked ___Steamed ___Boiled
___Broiled ___Poached ___Fried

What beverages do you drink daily and how much?
Coffee _____ times or 8 oz. glasses per day
Tea _____ times or 8 oz. glasses per day
Water _____ times or 8 oz. glasses per day
Alcohol _____ times or 8 oz. glasses per day
Other:_____ _____times or 8 oz. glasses per day

How many times each day do you have the following?

Starch	Never	1-2	3-5	6-8	9-11
Fruit	Never	1-2	3-5	6-8	9-11
Vegetables	Never	1-2	3-5	6-8	9-11
Dairy *(milk, yogurt)*	Never	1-2	3-5	6-8	9-11
Fat *(butter, mayo, oil, sour cream, cream cheese, ice cream)*	Never	1-2	3-5	6-8	9-11
Sweets *(candy, cake, regular soda, juice)*	Never	1-2	3-5	6-8	9-11
Protein *(meat, poultry, fish, eggs, cheese)*	Never	1-2	3-5	6-8	9-11

REVIEW OF SYSTEMS

Client Generated

Client Name: _____ Date: _____

Check (✓) either yes or no for each item except where applies to only male or female.

	Conditions	Yes	No
GENERAL	Fever		
	Chills		
	Bruise Easily		
	Swollen Glands		
	Loss of Memory		
	General Weakness		
	Aches/Pains		
ENT	Double Vision		
	Light Flashes		
	Blurred Vision w/o Glasses		
	Halos Around Lights		
	Ear Drainage		
	Buzzing/Ringing in Ear		
	Nosebleeds		
	Sinus Problems		
	Swallowing Problems		
	Deafness		
	Mouth, Tooth or Tongue Problems		
	Persistent Hoarseness		
	Severe Headaches		
	Other*		
SKIN	Rash		
	Changing Moles		
	Discoloration		
	Other Skin Problems*		
CHEST / HEART / LUNGS	Irregular Heartbeat		
	Shortness of Breath		
	Low Exercise Tolerance		
	Heart Flutters		
	Chest Pains		
	Frequent Coughs		
	Cough up of Blood		
	Wheezing		
	Night Sweats		
	Swollen Ankles		
	Cramps in Legs		
	Other*		

	Conditions	Yes	No
NECK	Stiffness		
	Swelling		
	Lumps		
	Other*		
GASTROINTESTINAL	Appetite Poor		
	Indigestion/Heartburn		
	Nausea		
	Vomiting Blood		
	Abdominal Pain or Cramps		
	Abdominal Tension		
	Diarrhea		
	Constipation		
	Bowel Habit Changes		
	Rectum Blood Passage		
	Black Tar-Type Bowel Movements		
	Other*		
KIDNEY	Up Nights to Urinate		
	Blood in Urine		
	Burning or Pain While Urinating		
	Problem Passing Urine		
	Trouble Controlling Urine		
	Other*		
MUSC	Leg or Arm Weakness		
	Balance Problems		
	Dizziness		
	Fainting Spells		
	Speech Problems		
	Other*		
BONES / JOINTS	Joint Pains		
	Joint Swelling		
	Muscle Strength Loss		
	Muscle Lump or Swelling		
	Lump on Bone		
	Pains in Back		
	Other*		
ENDOCRINE	Constant Thirst		
	Most Always Cold		
	Too Warm Most Times		
	Very Sluggish or Tired		
	Jumpy/Nervous		

	Conditions	Yes	No
PSYCHOLOGICAL	**Is your life:**		
	Satisfactory		
	Boring		
	Demanding		
	Unsatisfactory		
	Is there worry over:		
	Home Life		
	Marriage		
	Job		
	Children		
	Money		
	Do You:		
	Often Feel Depressed		
	Have Irrational Fears		
	Feel Things Often Go Wrong		
	Feel Upset		
	Feel Shy		
	Cry Easily		
	Feel Inferior		
	Have you:		
	Attempted Suicide		
	Seriously Considered Suicide		
MEN GENITALIA	Lump in Testicles		
	Penis Discharge		
	Breast Lump		
	Lesion on Penis		
	Erection Difficulties		
	Other*		
WOMEN GENITALIA	Breast Lump		
	Nipple Discharge		
	Vaginal Discharge		
	Non-Period Bleeding/ Spotting		
	Hot Flashes		
	Pain with Intercourse		
	Possibly Pregnant		
	Change in Periods		
	Pain Other than with Periods		
	Other*		

Explain Other*:

Client Name: _____ D.O.B.: _____

PHYSICAL ACTIVITY:

1. How many <u>times per week</u> do you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping?
   Circle number of days: None 1 2 3 4 5 6 7

2. How many <u>times per week</u> do you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration such as brisk walking, cycling, jogging, swimming, active sports, etc.?
   Circle number of days: None 1 2 3 4 5 6 7

PERSONAL HEALTH HISTORY:

Check each of the health conditions you have now or have had in the past. Please enter the approximate date of onset under each item marked.

<u>Cardiovascular</u>

- ❑ Heart Attack
- ❑ Angina
- ❑ Bypass Surgery
- ❑ Angioplasty
- ❑ Heart Valve Disease
- ❑ Heart Valve Surgery
- ❑ Pacemaker
- ❑ Defibrillator Implant
- ❑ Atrial Fibrillation
- ❑ Arrhythmias
- ❑ Mitral Valve Prolapse
- ❑ Stroke
- ❑ TIA or "Mini-stroke"
- ❑ Carotid Blockage
- ❑ Leg Artery Blockage
- ❑ Angioplasty to Legs
- ❑ Abdominal Aneurysm
- ❑ Bypass Surgery to Legs
- ❑ Stent Placement in Heart
- ❑ Stent Placement in Legs

<u>Pulmonary</u>

- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Recurrent Pneumonia
- ❑ Pulm Hypertension
- ❑ Restrictive Disease
- ❑ Lung Cancer
- ❑ Tuberculosis
- ❑ Chronic Bronchitis

<u>Psychosocial</u>

- ❑ Depression
- ❑ Stress
- ❑ Anxiety
- ❑ Nervous Disorder

<u>Musculoskeletal</u>

- ❑ Arthritis
- ❑ Low Back Pain
- ❑ Back Surgery
- ❑ Hip Replacement
- ❑ Knee Replacement
- ❑ Other Joint Surgery
- ❑ Fibromyalgia
- ❑ Myofascial Pain
- ❑ Rotator Cuff Disorder
- ❑ Scoliosis
- ❑ Chronic Fatigue

<u>Endocrine</u>

- ❑ Adrenal Issues
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Pituitary Disease
- ❑ Polycystic Ovarian Syndrome

<u>Other Conditions</u>

- ❑ Recurrent Infections
- ❑ Pancreatitis
- ❑ High Blood Pressure
- ❑ Neuropathy
- ❑ Seizures
- ❑ Breast Cancer
- ❑ Prostate Cancer
- ❑ Colon Cancer
- ❑ Other Cancer _____
- ❑ Bowel Polyps
- ❑ Inflammatory Bowel Disease
- ❑ Irritable Bowel Disease
- ❑ Reflux (GERD)
- ❑ Stomach Ulcer
- ❑ Hepatitis
- ❑ Cirrhosis/Liver Disease
- ❑ Weight Loss or Gain
- ❑ Kidney Disease
- ❑ Protein in Urine
- ❑ High Cholesterol
- ❑ Retinopathy
- ❑ Neuropathy
- ❑ Recurrent Infections

❑ Other _____

_____

Client Name: _____ D.O.B.: _____

SURGICAL HISTORY: (Please list all surgeries with approximate date):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Describe your current state of health: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

FAMILY HISTORY:

Please indicate whether your father, mother, sisters, brothers or grandparents have had any of the following conditions.

	Father	Mother	Brothers	Sisters	Grandparents
Living? Check if "yes"	❑	❑	❑	❑	❑
History unknown	❑	❑	❑	❑	❑
Heart attack, bypass surgery, angioplasty before age 55	❑	❑	❑	❑	❑
Heart attack, bypass surgery, angioplasty after age 55	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Elevated cholesterol or triglycerides or low HDL	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑
Other Cancer / Malignancy	❑	❑	❑	❑	❑
Arthritis, any type	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

SOCIAL HISTORY: Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Occupation: _____Current Employer: _____

How much caffeine (coffee, tea, sodas, etc.) do you drink? Number of servings per day? ____Per week? _____

How much alcohol do you drink? Number of drinks per day? ___Per week? ___Per month? ___for ___years

Do you use tobacco? ❑ No ❑ Yes ❑ Cigarettes ❑ Cigar ❑ Snuff / Chew When did you quit? _____

Number of packs per day? _____Number of years you smoked? _____

Have you ever used marijuana, cocaine, or other drugs? ❑ No ❑ Yes, which type: _____

Client Name: _____ D.O.B.: _____

MEDICAL / VITAMINS / SUPPLEMENTS / BIRTH CONTROL

Date of Last Menstrual Cycle: _____

Any Pregnancy Risk? _____No _____Yes

Name of pharmacy: _____Phone #: _____

Please list all MEDICATIONS, including vitamins, supplements and over-the-counter drugs:

Name of Drug	**Strength**	**Times per Day**

ALLERGIES (Medications, Latex)? Please list type of reaction next to each:

_____

_____

_____

_____

BLISSFUL WELLNESS MEDICAL WEIGHT LOSS CENTERS, LLC
2065 Herschel Street
Jacksonville, FL 32204
(904) 208-4040

NOTICE OF PRIVACY PRACTICES

Blissful Wellness Medical Weight Loss Centers, LLC ("Blissful Wellness") is required by Federal and Florida law to maintain a record of the medical services that you receive. In order to protect the privacy of our clients and the confidentiality of their medical records, we adhere to certain specific rules and procedures. Please read this entire document so that you may be familiar with our policies.

This NOTICE OF PRIVACY PRACTICES (the "Notice") describes how we may use and disclose your protected health information to carry out our treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your right to access and control your protected healthy information. "Protected Health Information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services. This Notice applies to all of your PHI maintained by Blissful Wellness, whether the PHI is created by your treating provider, by your referring physician, by a nurse, or by others working at or with Blissful Wellness. Blissful Wellness is required by law to abide by the terms of this Notice. In this regard, we are required by law to:

- Make sure that PHI remains private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this Notice as currently in effect.

Revision of Notice of Privacy Practices

We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all PHI that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised Notice at all Blissful Wellness offices. We will also make paper copies of the revised Notice available upon request.

Permitted Uses and Disclosures of Your PHI

Disclosures of your PHI will be made only with your authorization or the opportunity to object, unless otherwise permitted or required by law or authorized by you in writing. Examples of situations in which your PHI may be used and disclosed without your authorization include: (i) for the purposes of providing, coordinating and/or managing your treatment, obtaining payment for our services and supporting the business operations of our practice; (ii) if required by law or previously authorized by you in writing, (iii) in situations involving abuse, neglect or violence to you; (iv) for law enforcement activities or other specialized government functions; (v) if required by a court or administrative order, subpoena, discovery requires or other lawful purposes; (vi) if requested by a coroner, medical examiner or funeral director; (vii) if such disclosure does not personally identify you, unless previously authorized by you in writing; (viii) for research activities; and (ix) for public health and safety reasons. You may revoke this

authorization at any time, in writing, except to the extent that Blissful Wellness (or your assigned provider) has taken an action in reliance on the use or disclosure indication in the authorization.

Your Individual Rights:

1. **Right to request a restriction on the disclosure of your PHI.** You may request that we restrict or limit the PHI we use or disclose about you for treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice. Your request must be *in writing* and must state the specific restriction requested and to whom you want the restriction to apply. Blissful Wellness is not required to agree to any restrictions that you may request, but will make reasonable efforts to honor all such requests (unless ethical considerations or legal requirements dictate otherwise).
2. **Right to request confidential communications.** You have the right to receive communications from us in confidential manner, and you may request that we communicate with you about your PHI in a certain way (e.g., mail, email, phone) or at a certain location. Your request must be made in writing and must specify how and where you wish to be contacted. We will make reasonable efforts to accommodate all reasonable requests.
3. **Right to Inspect and Copy.** You may review and obtain copies of your PHI in designated record set at any time, subject to certain specific exceptions. Your request must be in writing and we may charge a reasonable fee for any copies requested and/or mailed. We will not deliver your medical records to you; you will be required to pick them up in person at one of our office location(s) with proper identification.
4. **Right to Amend.** You may ask us to amend your PHI if you believe that any of the information is incorrect or incomplete. Your request must be in writing and must specify the reason(s) for your request. Blissful Wellness may deny such requests in certain circumstances, but will provide you with a written explanation for the denial and information on any appeal rights you may have.
5. **Right to an Accounting.** You may request a written list of certain disclosures of your PHI made by Blissful Wellness. The request must be made in writing and must state the specific time period requested. The first request within a twelve (12) month period will be free of charge; any additional requests may be subject to a reasonable fee.
6. **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time.
7. **Complaints.** You have the right to file a written complaint with our office and/or the Secretary of the U.S. Department of Health and Human Services at any time if you believe that your privacy rights have been violated.

Contact Information

If you have any questions concerning this Notice, or if you would like to request documents or other information in writing or file a complaint, you may contact our privacy officer at _____

BLISSFUL WELLNESS MEDICAL WEIGHT LOSS CENTERS, LLC
2065 Herschel Street
Jacksonville, FL 32204
(904) 208-4040

NOTICE OF PRIVACY PRACTICES – CLIENT ACKNOWLEDGEMENT

I, _____, have received and understand Blissful Wellness's Notice of Privacy Practices (the "Notice"). I understand that:

- Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), I have certain rights to privacy regarding my Protected Health Information ("PHI");
- My PHI may be used by Blissful Wellness to: (i) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (ii) obtain payment from third-party payors; and (iii) conduct normal healthcare operations, such as quality assessments and provider certifications;
- The Notice provides in detail the uses and disclosures of my PHI that may be made by Blissful Wellness, my individual rights and Blissful Wellness's duties with respect to my PHI;
- Blissful Wellness reserves the right to change the terms of the Notice at any time and that I may contact Blissful Wellness at any time to obtain a copy of the current Notice;
- I may revoke this consent in writing at any time, except to the extent that Blissful Wellness has taken action in reliance on my consent.

BY MY SIGNATURE BELOW, I HEREBY AUTHORIZE DR. BLISSENBACH AND/OR BLISSFUL WELLNESS TO RESPOND TO ANY PUBLICLY AVAILABLE COMMENTARY CONCERNING DR. BLISSENBACH AND/OR BLISSFUL WELLNESS THAT HAS BEEN PREPARED OR PUBLISHED BY ME, OR ANY MY DIRECTION, IN ANY SOCIAL MEDIA (E.G., BLOGS, WEBSITES, NEWSPAPERS, BETTER BUSINESS BUREAU, ETC.) AND WAIVE MY RIGHT TO CLAIM A VIOLATION OF STATE OR FEDERAL PRIVACY LAWS IN CONNECTION THEREWITH.

Print Name: _____

Signature: _____
(of client or authorized representative)

Date: _____

Witness: _____

Client Informed Consent

Participation in a Weight Management Program

Client Name:_____ Date of Birth_____

I. Procedure and Alternatives:

1. I,_____(Client or Client's guardian) authorize _____and his (or her) associates or assistants to assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual Client. These may utilize a very low calorie diet, or a protein supplemented diet.
2. I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that I think maybe related to my weight control problem as soon as reasonably possible to the doctor treating.
3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive treatment will be dependent on my progress in weight reduction and weight maintenance.
4. I understand the medical exam by the Physician is not a complete exam. I have been advised that I still need to visit my Primary Care Physician for regular physical exams.

II. Risks of Proposed Treatment:

1. Vitamins and minerals - nausea, rash, constipation, diarrhea.
2. Potassium - heartburn, nausea.
3. Thyroid - vomiting, increased heart rate, chest pain, nervousness, tremors, menstrual irregularity, and/or nausea.

I understand that if I develop side effects from the diet or medication, I will discontinue the diet and/or the medication(s) and notify the medical staff as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (Take your medications with you)

III. Risks associated with Being Overweight or Obese:

1. I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies for high blood pressure, diabetes, heart attack, heart disease and arthritis of the hips, joints, knees, and feet. I understand that these risks may be modest if I am not very much overweight but the risks increases significantly the more overweight I am.
2. I understand that thirty (30) to forty (40) percent of overweight or obese Clients may have or develop gallstones. A large percentage of this group will develop symptomatic gallbladder disease during their lifetime. I understand that certain types of weight reduction programs may increase the chance of developing symptomatic gallbladder disease.

IV. No Guarantees:

- I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

- I understand that I will not receive any refund for any treatment if I am not successful. I understand that there is an initial fee, a fee every four weeks and a fee for products.

- I understand that I will not be able to return or receive funds for any product I purchase; it is my responsibility to inspect products before I leave the counter.

- I understand that if I cannot make a scheduled appointment, it is my responsibility to cancel within 24 hours. I understand that failing to do so will result in my being charged a "no show" charge for that appointment.

Initials:_____

V. Client's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if any items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I acknowledge that I have been provided a copy of Notice of Privacy Practices.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR HAVE ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

Date: _____ Time: _____

Signature: _____ Witness: _____

Client Signature or person with authority to consent for Client

VI. Physician Declaration:

I have explained the contents of this document to the Client and have answered all the Client's related questions to the best of my knowledge. I feel the Client has been adequately informed concerning the benefits and the 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 Client has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician Signature: _____ Date: _____

OPTIONAL TALENT RELEASE:

Talent hereby expressly grants to the weight loss center and its employees, agents, assigns or re-assigns, hereinafter known as the "Company", the unlimited and perpetual rights to use, copy, and distribute any photographs, images or likeness of Talent in any fashion for the promotion of the Company including commercial and non-commercial exposition which may include but is not limited to: printed media, television, video, or in any other medium.

I also hereby consent and agree that as part of this Agreement, I hereby grant the Company the unlimited right to photograph me otherwise record my image and likeness using any technology the company deems suitable and use said images or data in an unlimited fashion.

The Company shall not have any obligation to use Talent's image or likeness. I agree that I will not assert or maintain against you, your successors, assigns and licensees, any claim, action, suit or demand of any kind or nature whatsoever, including but not limited to, invasion of privacy, rights of publicity or other civil rights, or for any other reason in connection with your use of my physical likeness by the Company.

I certify that I am over 18 years of age and I am legally and mentally qualified to execute this agreement. I have read and fully understand the meaning and effect of this release and I agree to be legally bound by this agreement in its entirety.

Date: _____ Time: _____

Signature: _____ Witness: _____

Client Signature or person with authority to consent for Client

Client Informed Consent
Participation in a Weight Management Program

Program must be completed within 6 months, no exceptions. Program is nontransferable.

Date: _____

Client Name: _____

Signature: _____

(Client Signature or person with authority to consent for Client)

Witness: _____

Witness Signature: _____

Blissful Wellness
MEDICAL WEIGHT LOSS CENTERS

Blissful Wellness Weight Loss

Refund Policy

Once a package is chosen and purchased, I understand that there are no refunds.

Client signature: _____

Date: _____

Witness: _____

Date: _____

Patient Acknowledgement of Receipt of Policy

Should be kept in the Client's Charts

Privacy Policy of Blissful Wellness Medical

Weight Loss Centers, LLC

(And any of its affiliates, subsidiaries or assignee)

In order to protect the privacy of our patients and the confidentiality of their medical records, we adhere to certain specific rules and procedures. Please read this entire document so that you may be familiar with our policies.

Your information

Everything about your treatment with us is held in the strictest confidence. Our employees will not discuss anything about you with other patients, outsiders, their friends, their families, etc. They will only discuss with our other employees those matters concerning you that are necessary for the routine business of our offices.

We will not furnish any information concerning you to any person who makes inquires about you, whether in person, by phone, by fax, by e-mail, or by any other means of communication. This (perhaps unfortunately) extends to your family members, husbands, wives, friends, insurance companies, employers, etc.

Be assured that we will do everything necessary to keep your records from prying eyes.

If these rules seem overly strict, remember they are for your protection, and that we would rather err on the side of too much caution than too little.

Copies of Medical Records

You may always have access to your records.

We will only furnish copies of your medical records, either all or a part of them, to you personally. We will not mail them, fax them, send them by e-mail, or transmit them by any other method. They will be delivered in hand to you, and you will be asked to sign for them. We will not hand them to anyone else. You are then free to distribute them to whomever you wish. This applies to copies of your records regarding you, etc. This insures that no one will get any information about you unless it comes directly from you.

Date: _____ Time: _____

Signature: _____ Witness: _____

Client Signature or person with authority to consent for Client

Blissful Wellness
MEDICAL WEIGHT LOSS CENTERS

Blissful Wellness Weight Loss

No Show/Cancellation Policy

Patients that No Show or Cancel/Reschedule an appointment without giving 24 hours' notice will be charged a fee of $25.

Client signature: _____

Date: _____

Witness: _____

Date: _____