2237 N Commerce Parkway, Suite 3
Weston, Fl 33326
(954) 252-5454
Fax: (954) 314-9754

Patient Name: (Last)_____(First)_____
Patients Address:_____Email:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Cell Phone:_____
Birth Date:_____Age:_____Sex: M F Height:_____
Country Of Birth:_____Country Of Parents Birth:_____
Education: Elementary High School/Tech School 2-yr College 4-yr College Graduate
Insurance Company:_____ID:_____
Group Number:_____

Employment Information

Patient Employer:_____Occupation:_____
Employer Address:_____
City:_____State:_____Zip Code:_____
Work Phone:_____Ext:_____
Social Security:_____Drivers License:_____

In Case Of Emergency

Name:_____Relationship:_____Phone:_____
Patient's Spouse:_____ Phone:_____
Family Physician:_____Phone:_____
Referred by:_____

Financial Policy:

Thank you for selecting Dr. V. Manocchio, MD for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and out financial policy. Please be adviced that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and other major credit cards.

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

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

Patient's Name:_____ Date:_____

Patient's Signature:_____

Doctors Best
Weight Loss & Wellness Center
HEALTH • STAMINA • LONGEVITY

Wellness Program Consent Form

I_____authorize Dr. V. Manocchio, MD and whom ever they designate as their assistance, to help me in my weight reduction efforts. I understand that my program may consist of a balanced efficient diet, a regular exercise program, instructions and behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as an academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with the remaining overweight or obese's. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, physiological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight or tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden-death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity maybe a chronic, lifelong condition that may require changes and eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to the complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

I hereby further certify that I hold harmless American Physicians Weight-loss & Wellness centers, including Dr. V. Manocchio, MD of any damages that my treatment may cause to my help, including death. And I hereby release American Physicians Weight-loss & Wellness centers, associates, and Dr. V. Manocchio, MD of any liability or malpractice liability that potentially may arise in the future or in the present as a result of my taking this treatment. If you have any questions regarding the risks or hazards of this proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

DATE:_____ TIME:_____

WITNESS:_____ PATIENT:_____
(Or person with authority to consent for patient.)

Appetite suppressant consent, (you may wait and discuss in detail with your doctor prior to signing the section.)

I hereby of knowledge that I have received and understand the information on this medication that I am requesting. Phentermine or _____. I am aware of the side effects and adverse reactions to the Strug as well as the potential damage to my help and I still decide to receive the medication. I hereby further certify that I hold harmless American Physicians Weight-loss & Wellness and Dr. V. Manocchio, MD of any damages that the medication may cause my health, including death. And I hereby release American Physicians Weight-loss & Wellness, associates, and Dr. V. Manocchio, MD of any liability or malpractice liability that potentially may arise in the future or in the present as a result of my taking this medication.

PATIENT:_____
(Or person with authority to consent for patient.)