Glimpse

Weight loss - Cosmetics - Wellness

Jill Oliver M.D.

Patient Information Sheet

Please fill out this form in print and answer as many questions as possible. Items in **BOLD** are **REQUIRED.**

Legal Last Name:	**First Name:**	**MI:**
Marital Status:	**Gender:**	
Date of Birth: / /	**Social Security Number: - -**	
Street Address:	**Apartment #:**	
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	
Employer:	**Your Email:**	
How were you referred to our program? (Circle One):	**Physician** **Brochure** **Print Ad** **E-Mail**	
Special Event **Family/Friend** **Referring Person's Name:**		

Consent to Use Images/Video and Release of Rights (Optional)

_____ (Initial) With respect to all photographs and video footage that may be taken of me, I hereby **grant** to Glimpse the unrestricted right to copyright said imagery and to use and publish same in whole or in part and in any media for any purpose whatsoever, including but not limited to advertising, promotion, marketing, research, physician and patient education. I hereby release Glimpse, its successors, affiliates and assignees from any claim, demand, and cause of action or proceeding of whatever nature arising out of any use, publication and/or distribution of my photographs in accordance with the terms of this authorization.

_____ (Initial) I **decline** consent to use images/video (may be amended at later date *ONLY* with written consent)

Consent to Allow Access to Protected Health Information

_____ (Initial) With respect to any and all of my Protected Health Information (PHI), I hereby **grant** the following persons and/or agencies access at any time:

Name of Person/Agency: _____

_____ (Initial) I **decline** consent to allow access by outside parties *not otherwise permitted by law* to my PHI (may be amended at later date *ONLY* with written consent)

If patient is under 18 or under the care of a legal guardian:	
Guardian's Name:	**Guardian's DOB: / /**

Emergency Contact

Name:	**Relationship:**	**Phone:**

The above information is true to the best of my knowledge:

Signature:	**Date:**

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PATIENT MEDICAL HISTORY

PRESENT MEDICAL HISTORY

Are you under a doctor's care at the present time? Yes / No

If yes, for what? _____

Do you have a family/primary care physician in the Las Vegas area? Yes / No

If yes, physician name: _____

If not, are you currently looking for a family/primary care physician? Yes / No

Are you taking any prescribed medications at the present time? Yes / No

Med: _____ Dosage: _____ | Med: _____ Dosage: _____

Med: _____ Dosage: _____ | Med: _____ Dosage: _____

When was the last time, if ever, that you have had laboratory blood tests performed? _____

(Females Only) Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Are you currently on hormone replacement therapy (HRT) or birth control pills (BCP)? Yes / No

Estrogen Progesterone Testosterone Growth Hormone BCP: _____ Other: _____

Are you currently taking any vitamins or health supplements? Yes / No

Multivitamin L-Carnitine CLA Anti-oxidants Protein bars/shakes Other: _____

Do you have any allergies or adverse reactions to medications or substances (such as latex)? Yes / No

Med: _____ Reaction: _____

Med: _____ Reaction: _____

Do you smoke? Yes (Currently) No (But I have in the past) No (Never)

Pack(s)/Day: _____ Quit Date: _____

Do you drink alcohol? No 1-7 drinks/week More than 7 drinks/week Type: _____

Do you drink coffee? Yes / No Soda? Yes / No # cups/cans/bottles per day: _____

Do you currently exercise? Yes / No How often: _____

If yes, do you ever experience chest pain, heart palpitations, shortness of breath, back/neck pain, headache, vision problems, extremity pain/numbness or other symptoms? Yes / No

Current place of employment: _____ Hours/week: _____

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PAST MEDICAL HISTORY **(Please circle all that apply)**

Allergies: food sensitivities, bee stings, seasonal rhinitis, other: _____

Bleeding Problems: anemia, hemophilia, taking "blood thinners," other: _____

Cancer/Precancerous changes (dysplasia): _____

Cardiac Issues: chest pain, hypertension, heart attack (MI), irregular heartbeat (arrhythmia), palpitations, bypass surgery, pacemaker, other: _____

Circulation Issues: blood clots, DVTs, poor leg circulation, feet swelling, other: _____

Diabetes-related Issues: eye problems, kidney problems, neuropathy, other: _____

Digestive Issues: nausea, reflux (GERD), constipation, bloating, diarrhea, peptic ulcers, gluten sensitivity (sprue) gall bladder problems, other: _____

Eye Issues: glaucoma, cataracts, other: _____

Joint Issues: osteoarthritis, rheumatoid arthritis, fibromyalgia, osteoporosis, other: _____

Kidney Issues: kidney stones, urination problems, prostate problems, other: _____

Lung Issues: asthma, COPD, sleep apnea, other: _____

Neurological Issues: migraines, stroke, other: _____

Psychological Issues: anxiety, depression, anorexia, bulimia, alcohol abuse, drug abuse, diagnosed mental illness, other: _____

Skin/Hair Issues: acne/acne scarring, easy bruising, excess scarring, wrinkles, cellulite, spider veins, age spots, hair in unwanted areas, thinning hair/hair loss, other: _____

Surgery: Type: _____ Date: _____ | Type: _____ Date: _____

FAMILY HISTORY

Has any blood relative ever been diagnosed with any of the following medical conditions?

Diabetes	Yes / No	Who: _____
Glaucoma	Yes / No	Who: _____
Heart Disease/Stroke	Yes / No	Who: _____
High Blood Pressure	Yes / No	Who: _____
Kidney Disease	Yes / No	Who: _____
Psychiatric Disorder	Yes / No	Who: _____
Thyroid Problems	Yes / No	Who: _____

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DIET HISTORY

What is the primary reason for your decision to lose weight?

____ Want to look better ____ Doctor told me I had to ____ Concerned for my health

____ I want to feel better ____ Need to for my job / a special event

When did your weight problem start?

____ Childhood ____ Adolescence ____ After pregnancy ____ After menopause

____ Came on gradually ____ Came on suddenly (give reason: _____)

If it came on suddenly, what was your age and usual weight prior to the gain? ____ yrs _____ lbs

What was your heaviest weight and what was your age at the time? ____ yrs _____ lbs

Have you ever used any of the following weight loss methods?

Prescription Diet Pills Yes / No List: _____

Natural Supplements Yes / No List: _____

Food plans Yes / No List: _____

Other Yes / No List: _____

Foods/drinks you crave (circle all that apply): chips, chocolate, nuts, ice cream, sweets of any kind, salty foods, soda, caffeinated beverages, other _____

What time of day or night are you the hungriest? _____

Do you awaken hungry during the night? Yes / No If yes, number of times/week: _____

Do you ever have eating binges? Yes / No

When you are under stress either at work or due to personal reasons, do you tend to eat more? Yes / No

Do you feel that you are currently under a lot of stress or experiencing an emotional upset? Yes / No

Describe your typical energy level over the past few months: (check the statement the best applies)

_____ I sometimes miss work because I am so tired.

_____ I rarely miss work but I am usually too tired to do anything active when not working.

_____ I do other activities when not at work but I am usually too tired to exercise.

_____ I am not usually fatigued and I exercise 1-3 times per week.

_____ I am not usually fatigued and I exercise 4 or more times per week.

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How many hours of television do you watch each day (includes playing video games)? _____

Have you ever considered bariatric surgery? (stomach stapling, gastric bypass, gastric band) Yes / No

Number of glasses or ounces of water you drink daily on average: _____

Please list your average daily food intake: (Please be as specific as possible, including # of sodas, etc.)

Breakfast: _____

Mid-morning Snack: _____

Lunch: _____

Mid-afternoon Snack: _____

Dinner: _____

Late Night Snack: _____

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DISCLAIMERS & WAIVERS

_____ (**initial) Financial Waiver**

I understand that the **Glimpse** weight loss program (and affiliated programs) and all medications, supplements, cosmetic products and procedures, and certain elective injections will NOT be billed to my insurance company. I understand that I will be responsible for all charges incurred for these products, services and procedures and that payment is due no later than time of service.

_____ **(initial) Elective Injections**

I understand that certain injections are considered elective and are *not* covered by most insurance providers. Injections such as vitamin injections, diet shots, hormone replacement, folic acid, naturopathic and other injections are *not* covered. I understand that I will be responsible for *all* charges incurred for these services and that payment is due no later than time of service.

_____ **(initial) Controlled Substances and Prescriptions**

Controlled substance medications are closely monitored by various government agencies. Used properly, many medications under this classification can be highly effective for pharmacological therapeutic treatment of a variety of conditions. To ensure these medications are used correctly, I agree to the following:

1. I am responsible for my own medications. If a prescription or medication is lost, stolen or misplaced, or used sooner than expected based on the prescription, I understand that the prescription will **NOT** be replaced.
2. I will **NOT** request nor accept *the same nor chemically similar* controlled substance medication prescriptions from any other physician or individual while I am receiving such medications from **Glimpse** (unless I am hospitalized).
3. I understand that while a patient of Glimpse Medical/Dr. Jill Oliver that my record of dispensed controlled substances will be monitored under the PMP (Prescription Monitoring Program) per Nevada State law.
4. I understand there may be a turnaround time of 24-48 hours for refills of all prescription medications. Therefore, I understand I should not wait until my medications are completely used prior to requesting a refill. I also understand that renewed prescriptions of controlled substances require an office visit and that such renewals will **ONLY** be made during office hours.
5. I understand that violating **ANY** of these terms may result in my being discontinued as a patient.

_____ **(initial) Privacy Practices**

I have received a copy of this medical practice's Privacy Practices. I understand that these practices can change over time reflecting changes in federal, state, and local law and that **Glimpse** extends its best efforts to safeguard my Protected Health Information (PHI).

I have read and understood the disclaimers and waivers.

_____ _____

Print Name **Date**

_____

Signature

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NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information may or may not be used and disclosed and the means by which you, our patient, may access this information. **Please review it carefully.** The *Health Insurance Portability and Accountability Act* (HIPAA) is federal legislation designed to limit gaps in health insurance coverage and to improve the privacy, access, and disclosure of personal health information. HIPAA regulations set tight boundaries on the use and release of health records and give patients more control over and access to their *Protected Health Information* (PHI), enabling them to find out how their PHI may be used, and in regards to certain disclosures of their information when such disclosures are made. PHI is defined as any information that may identify or be used to identify a patient *and* that relates to: past, present or future physical or mental health care or condition; health care services provided; payment for health care. **It has always been the policy of Glimpse to maintain our patients' records with the utmost of respect, care, safety and confidence.** In certain areas, state or other regulations may be more stringent than HIPAA. It is the policy of **Glimpse** to always abide by the most stringent of regulations as they pertain to PHI. **We will make every reasonable attempt to keep Protected Health Information (PHI) a confidential matter between Glimpse and you, our patient.**

Use and Disclose of Your Protected Health Information

1. **Glimpse may use or disclose your Protected Health Information for purposes of treatment, payment or healthcare operations without your prior authorization.** Your PHI may be made accessible to our providers and staff for the purpose of providing care and services related to the practice. We may also use your PHI for internal purposes, including but not limited to determination of practices to provide better care and services and/or employee review. As most health insurance companies and policies do not cover our services, we will not send your insurance carrier information regarding any services or care provided without your prior *written* authorization. We may access or send your PHI to our attorneys, accountants, or other personnel in the event such information is required in the course of our business function.

2. **Protected Health Information may also be used without prior consent when:**
   Required by Law or Subpoena: PHI will be used and disclosed when the law requires it. Examples of such requirements include: communicable disease or infection exposure reporting, abuse, product recalls or failures, and reactions to medications. PHI may be used and disclosed to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person or, in some cases, to comply with a court order or subpoena and for other law enforcement purposes.
   For Health Oversight Activities and Requirements: PHI may be used and disclosed to health agencies during the course of audits, investigations, surveys, accreditations, certifications and other proceedings.
   For Research: PHI may be used and disclosed in order to prevent or lessen a serious and imminent threat to the health and/or safety of others.

3. **Required Uses and Disclosures:** Under the law, disclosures must be made to you, our patient, upon request in most circumstances and when required by the Department of Health and Human Services to investigate or determine compliance with HIPAA regulations.

4. **For all other circumstances, Glimpse may only use or disclose your Protected Health Information with your written authorization.** If you, our patient, authorize **Glimpse** to use or disclose your PHI, you may revoke your authorization in writing at any time. However, if **Glimpse** has disclosed or used your PHI based on a revoked authorization, nondisclosure may not be possible.

5. **We may also use or disclose your Protected Health Information for:**
   Appointment Reminders: **Glimpse** may contact you with appointment reminders or to provide information on other treatments or services that may be of interest to you.
   Change of Ownership: In the event that **Glimpse** is sold or merged with another organization, your PHI will become the property of the new owner. Although any new management will have obligations to keep your data private under HIPAA as required by law, their exact policies may differ from those in effect and use at **Glimpse**.

Insurance Billing: Your designated insurance carrier/payer may require documentation of services or other information contained in your PHI. For purposes of billing the payer that you, our patient, have designated your PHI may be shared in ways consistent with HIPAA regulations. Your payer is responsible for abiding by the law and their privacy policies with regard to protecting your PHI.

Rights With Respect to Protected Health Information

You, our patient, have the right to request restrictions on the use and disclosure of your PHI. You have the right to request your PHI through confidential means. **Glimpse** will not require an explanation from you prior to disclosing your PHI to you upon request. You must specifically state how and where to send any records, documents, or materials in our possession that contain PHI. Such request must be in writing and be addressed to the Privacy Officer as listed below.

You, our patient, have the right to inspect your PHI. You may also obtain copies of your PHI with few exceptions. **Glimpse** may charge a reasonable fee for the copying and/or mailing of records. You have the right to request that **Glimpse** amend your PHI if you believe it is incorrect or incomplete. **Glimpse** reserves the right to deny such a request if it is believed to be accurate as written.

You, our patient, have the right to receive an accounting of disclosures of your PHI performed, facilitated, or overseen by **Glimpse**, except those authorized by you, those made for treatment or other health care operations, those provided without personally identifiable information, and/or disclosures required by law, among other disclosures not named herein but accepted as exempt from this right. The right to receive an accounting is subject to exceptions and limitations as provided for by the relevant agencies and situations that permit it.

You, our patient, have the right to a paper copy of the current Notice of Privacy Practices upon request. If you would like to obtain a more detailed explanation of these rights, or if you would like to exercise one or more of the rights listed herein, you may contact the Privacy Officer as listed below.

Glimpse's Duties to Its Patients

Glimpse is required by law to maintain the privacy of your Protected Health Information and to provide you, our patient, with a copy of this Notice and is also required to abide by the terms of this Notice. **Glimpse** reserves the right to amend this Notice at any time in the future and to make the provisions in the amended Notice applicable to your PHI in its entirety, regardless of whether or not it was created prior to the amendment of the Notice. If such an amendment is made, **Glimpse** shall immediately display the revised Notice at our office and provide you with a copy of the current Notice at any time, upon request.

Contacting Glimpse With Regards to Privacy Practices

If you have any questions, concerns, or problems regarding your Protected Health Information, or if you want more information regarding **Glimpse's** compliance with HIPAA and the management of its patients' PHI, please do not hesitate to contact our Privacy and Compliance Officer (Anthem Office):

Henry Crossen
Glimpse Practice Manager and Privacy & Compliance Officer
10170 S. Eastern Ave #100; Henderson, NV 89052
Phone: (702) 405-5660; Fax (702) 405-5661