Medically Assisted Weight Loss Program

VISIT ONE: New Patient MEDICAL EVAL FORM

Date of Visit: _____		
Last Name	**First Name**	**DOB:**
Home Phone:	**Cell Phone:**	**Birth Gender**
		CIRCLE: MALE OR FEMALE
Pharmacy Name	**Pharmacy Phone Number**	**Referred to us by**

How does your weight affect your life and health?

At what weight did you feel your best?

How old were you?

What was your activity level?

What was your diet like?

WEIGHT HISTORY:

When did you first notice that your were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in 3 months? ☐ Yes ☐ No

If so, when? _____ **How much weight did you gain?** _____

Life events associated with weight gain (Check all that apply)

☐ Marriage
☐ Divorce
☐ Pregnancy
☐ Illness
☐ Travel
☐ Injury
☐ Job
☐ Stress
☐ Drugs
☐ Alcohol
☐ Parties
☐ Boredom
☐ Eating Out
☐ Anger
☐ Insomnia
☐ Job Change
☐ Quitting Smoking
☐ Seeking Reward

Other

Food Cravings: (Check all that apply)

☐ Starches
☐ Salty
☐ Fast Food
☐ High Fat
☐ Sugar
☐ Chocolate
☐ Crunchy
☐ Soda
☐ Milk
☐ Juice
☐ Coffee with cream and sugar Home or Coffee Shop?_____

Favorite Drink?

How many sodas do you drink a day?

Name:		Date

Previous weight-loss programs tried: (Circle all that apply):

Weight Watchers **Nutrisystem Diet** **Zone Diet** **Jenny Craig** **Medi fast Diet** **LA Weight Loss**

South Beach **Dash Diet** **Atkins Diet** **Paleo Diet** **Keto Diet** **Mediterranean Diet** **Ornis Diet**

What was your maximum weight Loss on this diet? _____

What are your greatest challenges with dieting?

_____

_____

Have you ever taken medication to lose weight? (Circle all that apply):

Phentermine **Meridia** **Xenical** **Phen Fen** **Phendimetrazine** **Topamax** **Belviq**

Qsymia **Bontril** **Contrave** **Saxenda** **Wellbutrin** **Dosymia** **Diethylpropion**

Other: _____

What Worked?

What did not work?

Why or why not?

FITNESS HISTORY:

Exercise type:

Duration: _____ **Hour (s)** _____ **minute(s)**

How many times per week?

Does anything limit you from exercising? _____

How many hours do you sleep at night? _____ **Do you feel rested in the morning? Yes or No**

Have you had a Sleep study? Yes or No If so when? _____

Have you ever been diagnosed with an eating disorder? Yes or No?

If yes, Which one? _____

NUTRITIONAL HISTORY:

How often do you eat breakfast? _____ **Day per week @ what time?** _____**AM?**

Number of times you eat per day. _____**?**

Do you get up at night to eat? Yes or No If so, how many times during night? _____

Do you have any food intolerances/Restrictions?

Name:		Date

Food recall over the last 24 hours (please list):

Breakfast	
Lunch	
Dinner	
All Snacks through Day and Night	
What did you drink in last 24 hours?	

PAST MEDICAL HISTORY (Check all that apply):

- ☐ Heart Attack
- ☐ Angina
- ☐ Stroke
- ☐ Diabetes
- ☐ Infertility
- ☐ Gallbladder Stones
- ☐ High Blood Pressure
- ☐ Celiac Disease
- ☐ Indigestion/Reflux
- ☐ Pancreatitis
- ☐ Gout
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ High Cholesterol
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Kidney Stones
- ☐ Thyroid Cancer
- ☐ CVA
- ☐ Thyroid Disorder
- ☐ Polycystic Ovarian Syndrome
- ☐ Sleep Apnea
- ☐ High Triglycerides

Cancer: List Type:

PAST SURGICAL HISTORY (circle all that apply):

Gastric Bypass Gastric Banding Gastric Sleeve Hysterectomy Heart Bypass Other: _____

MEDICATIONS/ALLERGIES:

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

SOCIAL HISTORY: Circle

Smoking: NEVER CURRENT OCCASIONALLY FORMER REGULAR USE: How many a day? _____
Alcohol Use: NEVER CURRENT OCCASIONALLY FORMER REGULAR USE: How many a day? _____
Drugs: NEVER CURRENT OCCASIONALLY FORMER REGULAR USE: How many a day? _____
Marijuana NEVER CURRENT OCCASIONALLY FORMER REGULAR USE: How many a day? _____

Have you had prior treatment for alcoholism? Yes or No

FAMILY HISTORY:

Obesity: Mother Father Sibling Child
Diabetes: Mother Father Sibling Child

Mother: □ Alive □ Deceased (medical history) _____
Father: □ Alive □ Deceased (medical history)
Sibling: □ Alive □ Deceased (medical history)
Sibling: □ Alive □ Deceased (medical history
Child: □ Alive □ Deceased (medical history
Child: □ Alive □ Deceased (medical history) _____
Please list any additions Siblings or children below:
□ Alive □ Deceased (medical history) _____
□ Alive □ Deceased (medical history) _____

Name:		Date

WOMEN ONLY:

Are you sexually Active? Yes, or No Contraceptive Medication/Method? _____

Number of Pregnancies? _____ Number of Children? _____ Age at last pregnancy? _____

Periods: (Circle) Regular Heavy Normal Light Irregular Absence of period

Hot Flashes? Yes or No Facial Hair? Yes or No Change in bladder Habits? Yes, or No

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY):

Recent weight loss more than 10 pounds
Recent weight gain more than 10 pounds
Swelling in ankles/extremities
Dysphagia/difficulty swallowing
Gas and bloating
Back pain
Weakness/low energy
Mood changes
Heat intolerance
Shortness of breath
Abdominal pain
Indigestion
Urinary frequency/Urgency
Joint pain
Anxiety
Nervousness
Blood clots
Chest pain
Bloating
Nausea/vomiting
Slow urine flow
Seizures

Acne
Difficulty breathing when flat.
Constipation
Increased appetite.
Nighttime urination
Dizziness
Insomnia
Cold intolerance
Skin rash
Fainting/blacking out
Diarrhea
Decreased appetite.
Blood in stool
Headaches
Memory loss
Excessive sweating
Cough
Palpitations
Food intolerance
Heartburn
Muscle aches/pains

Comments:

Patient Name:

PARAGON
Health Partners
PAIN - OBESITY - ADDICTION

Date:

DOB:

Completed on Initial Visit

Why I Want to Control my obesity...

- **On a scale from 0 (no motivation) to 10 (100% motivated); How committed are you to controlling your obesity? _____**

- **Why not a lower number?**

  _____

  _____

  _____

  _____.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list three reasons you want to take control of obesity:

-

-

-

Describe the functional benefits you hope to get by controlling your obesity:

Describe the medical benefits you hope to get by controlling your obesity:

Patient Name:

PARAGON
Health Partners
PAIN · OBESITY · ADDICTION

Date:

Why I Want to Lose Weight...

Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to lose weight:

Describe the physical benefits you hope to get by losing weight:

Describe the psychological benefits you hope to get by losing weight:

Comments:

Patient Health Questionnaire (PHQ-2 & PHQ-9)

Patient please complete both the PHQ 2 & PHQ 9	
Name *(last, first)*	
Birthdate *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female
Today's Date:	

PHQ 2		
1. During the **past two weeks**, have you often been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No
2. During the **past two weeks**, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes	☐ No
If the answer to both questions is No, the screen is negative for depression *(re-screen if indicated)*. If yes was selected for one or both questions, please consult appropriate discipline to complete the PHQ-9.		
Date *(yyyy-Mon-dd)*	Signature	

PHQ 9				
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	**Not at all** (score = 0)	**Several days** (score = 1)	**More than half the days** (score = 2)	**Nearly every day** (score = 3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
TOTAL	0 +	+	+	+
TOTAL SCORE				

If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 Score	Meaning / Action
Less than 5	Patient not likely depressed, re-screen if affect changes. Communicate results to the team and to any referral sites.
Between 5-9	Watchful waiting - patient to be closely monitored and re-screened if needed. Communicate results to the team and any referral sites.
Greater than 9	Patient has screened positive and requires further assessment by a certified professional for diagnosis and treatment. Notify attending, consider consulting psychiatry or psychology. Communicate results to the team and any referral sites.

Date *(yyyy-Mon-dd)*	Signature

Paragon Health Partners
2895 Lewis Lane Paris, TX 75460

Office Phone: 972-203-3600
Office Fax: 972-203-3601
Office Email: info@paragonphp.com
Website: www.paragonphp.com

Today's Date:_____

Name _____
Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP	Yes	No
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	☐	☐
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	☐	☐
Has anyone **O**BSERVED you stop breathing during your sleep?	☐	☐
Do you have or are you being treated for high blood **P**RESSURE?	☐	☐

BANG	Yes	No
BMI more than 35kg/m2?	☐	☐
AGE over 50 years old?	☐	☐
NECK circumference > 16 inches (40cm)?	☐	☐
GENDER: Male?	☐	☐

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

Tobacco Use Assessment Form

Name: _____ **Today's Date:** _____

Date of Birth: _____

1. **Have you ever smoked cigarettes or used any other tobacco product?**
   ___ Yes
   ___ No

2. **Do you currently smoke cigarettes or use any other tobacco product?**
   ___ Yes
   ___ No -- Date Stopped _____

   If you answered yes to questions 1 or 2, please answer the following:
   Type of tobacco and brand name _____
   Length of use (in months or years) _____
   Amount used per day on average _____

3. **Does anyone you live with or who is close to you smoke cigarettes or use other forms of tobacco?**
   ___ Yes
   ___ No

   (Continue only if you answered *Yes* to #2)

4. **How soon after you wake up do you smoke your first cigarette or use other forms of tobacco?**
   ___ Within 30 minutes
   ___ More than 30 minutes

5. **How interested are you in stopping smoking or stopping use of other forms of tobacco?**
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

6. **If you decided to quit smoking or using other forms of tobacco completely during the next 2 weeks, how confident are you that you would succeed?**
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

7. **Have you ever intentionally quit smoking/using other forms of tobacco for 24 hours or longer?**
   ___ Yes ___ No

   In the past year? ___ Yes ___ No
   In the past month? ___ Yes ___ No
   Since the last visit? ___ Yes ___ No

(Reproduced with modifications from Glynn and Manley, 1998)

ALCOHOL MISUSE/ABUSE (AUDIT C)

1. Did you have a drink containing alcohol in the past year?
    - Yes
    - No
2. If 'Yes': How often did you have six or more drinks on one occasion in the past year?
    - Never
    - 2 to 4 times a month
    - 2 to 3 times per week
    - 4 or more times a week
    - Decline to specify.
3. If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
    - 1 or 2 drinks
    - 3 or 4 drinks
    - 5 or 6 drinks
    - 7 to 9 drinks
    - 10 or more drinks
    - Decline to specify.
4. If 'Yes': How often did you have a drink containing alcohol in the past year?
    - Never
    - Monthly or less
    - 2 to 4 times a month
    - 2 to 3 times a week
    - Daily or almost daily
    - Declined to specify.

Patient Name **Date:**

Consents	Initital
Consent For Treatment: I hereby consent to the treatment by the providers at Paragon Health Partners and its employees or designees. I auathorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.	
Consent for Medication History: I authorize Paragon Health Partners and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication History.	
Consent of Picture for Electronical Medical Record Chart: I understand and consent and authorize that my photo is taken for my Electronical medical record chart. If I am being treated for obesity medicine this picture will be attached to my progress note.	
Authorization for Release of personal health Information: I aurthorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applicationts ofr financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release clinical information related to my diagnosis and treatments for pain management, addiction medicine, alcohol or opioid, street drugs use, obesity medicine, which may be requested by my insurance or its designated agent.	
Assignment of Insurance Benefits/Payment Gurantee/Collection Fee: I authorize payment to be made directly to Paragon Health Partners, Paragon Primary Care, Paragon Pain & Rehabilitation, and/or any of its providers. For insurance payment payable to me. I understand that I am financially responsible to practice for any non-coverred servcies , as defined by my insurer. I understand that if my account balance becomes overdue if may be referred to collection agency. I understand payment is due at time of service.	
Privacy Policy: I acknowledge having received Paragon Health Partners, "Notice of Privacy Practices" My rights including the right to see a copy of my medical records, to limit disclosure of my health information, and to request an amendment to my record, is explained in the policy. I understand that I may revoke in writing my consent fo release of my healthcare information, excep to the extent Paragon Health Partners has already made disclosures with my prior consent.	
Disclaimer: By Typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this paperwork from Paragon Health Partners.	
Payment Policy All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.	
Late/No Show/Cancellation Fees: Late is considered arriving for New Evaluation less than 30 minutes prior to appointment time. You can be rescheduled and will be charges a $50.00 Fee. Late for a Follow Up over 5 minutes will be rescheduled and charged a $25.00 Fee. A missed appointment, reschedule less than 48 hours prior will result in a $50.00 Fee, and a $25 fee if it is a follow up appointment . Telemedicine or Office Appointment.	

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____
Patient Name (Printed)

_____
Responsible Party (Printed) (If patient is a minor or dependent adult)

Patient Signature Date

New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

Preferred Pharmacy	I understand I am only allowed to use ONE pharmacy by Paragon	☐ Yes	☐ No
Pharmacy Name	Pharmacy Location		

Patient Information

Name (First, Middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Employer (or parent/guardian employer if patient is a minor)				Work Phone	
Primary Care Provider (where you go for your routine medical care)					
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Medicare Patient: Are you enrolled in Chronic Care Management with PCP?

Medicare Patient: Are you enrolled in Remote Patient Monitoring with any Physician?

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.
2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.
3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).
4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.
5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

Signature

PARAGON
Health Partners

Medical Record Release of Information

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name:
PARAGON HEALTH PARTNERS/PARAGON PAIN & REHABILITATION
Address 2895 Lewis Lane Paris, TX 76034
Phone (972)-203-3600 Fax (972) 203-3601 Email: info@paragonphp.com

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

PARAGON
Health Partners

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a a minor)

Date Signed _____/_____/_____

PARAGON
Health Partners

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

As a health care provider, we are committed to maintaining the privacy and confidentiality of your health information in accordance with Federal and State law and we are required by law to provide you with this Notice of Privacy Practices (Notice) that describes how health information that we maintain about you may be used or disclosed. This Notice also describes your rights and the obligations we have regarding the use and disclosure of health information. This Notice applies to Paragon Pain Rehabilitation LLP d/b/a Paragon Health Partners and Paragon Primary Care, PLLC d/b/a Paragon Health Partners, which are separate legal entities that are under common ownership and control and have thus organized themselves as a single Affiliated Covered Entity (Paragon) for purpose of compliance with the Health Insurance Portability and Accountability Act (HIPAA). This status permits Paragon to maintain a single Notice of Privacy Practices and to share health information as one organization as described in this Notice. Each of the Paragon entities will follow the terms of this notice.

Uses and Disclosures of Your Health Information
We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

Other Uses of Your Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you 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 organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Changes to this Notice.

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

Complaints

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint. **Privacy Officer**

For further information, please contact our Privacy Officer, Karen McNerney at: **POBox 1200 Colleyville, TX 76034 (972) 203-3600**

4881-1519-2356.2

PARAGON
Health Partners
PAIN • OBESITY • ADDICTION

OBESITY PROGRAM CONSENT FORM

I, _____, authorize Paragon Health Partners to help me in my weight-reduction efforts. I understand that my program may consist of a diet, increase in physical activity, instruction on behavior modification, and the use of anti-obesity medications.

I understand that any medical treatment may involve risks as well as benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks associated with obesity management programs are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and other heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with having obesity may include but are not limited to: high blood pressure; diabetes; heart attack; heart disease; cancer; arthritis of the joints, including hips, knees, feet, and back; sleep apnea; and sudden death. I understand that these risks may 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 that my plan will be successful. I also understand that obesity is a chronic, lifelong condition that will require permanent changes in eating habits, activity level, and behavior to be effective.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Date

X_____

Patient Signature

PARAGON
Health Partners
PAIN - OBESITY - ADDICTION

Patient Name:

Date:

CONSENT FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI- OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND THE PROVIDER DECIDE UPON THEIRUSAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered "controlled medications." By law, a controlled medicationcan only be prescribed from one facility at a time; therefore, I agree that only Norberto Vargas, M.D. and Chelsey Hinkle,NP-C or a covering provider at Paragon Health Partners will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Paragon Health Partners, and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use.** I agree that I will be honest in disclosing this information and will notify my provider(s) of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I understand that taking medications in any way other than as directed and prescribed could affect myhealth and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at Paragon Health Partners are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti- obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider (s).

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as anadjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature:_____Date:_____

Patient Name (printed):_____

PHENTERMINE INFORMED CONSENT

Date: _____ DOB: _____

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the programs with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through Paragon Health Partners. I understand there is no guarantee for the effectiveness of Phentermine.

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release Paragon Health Partners and their medical providers and facility from any liability associated with this treatment.
Initials: _____

I understand Phentermine treatments may involve these risks and other unknown risks:

- I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding.
- I understand that it is my responsibility to inform Paragon Pain & Rehabilitation, LLP, and Paragon Primary Care, PLLC. and their medical providers if I am pregnant if I am trying to become pregnant or if I become pregnant during these treatments.
- I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release Paragon Health Partners and their medical providers and facility from any liability arising because of this.
- I understand that I may quit the program at any time. While adverse side effects or complications are not expected, if an illness does occur, I understand that I need to contact the office at 972-203-3600 or call 911 immediately.
- If I experience an emergency, I understand that I need to go to an emergency facility.
- I understand that if there are any changes in my medical history or are any changes in my medications or any other changes relevant to this procedure, I will advise Paragon Health Partners and their medical providers at that time.
- I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and Paragon Health Partners, and their staff from any liability associated with this treatment. In the event a dispute arises over the outcome of the treatment, I consent solely to arbitration as a legal means of settlement.

Patient Name (Printed) _____

Patient Name (Signature) _____

PARAGON
Health Partners
PAIN - OBESITY - ADDICTION

Patient Name:
Date:
Provider Name:
Telemedicine Site:

Informed Consent to Telemedicine Consultation

I have agreed to be seen for my appointment via a telemedicine consultation and or follow up visit with Paragon Health Partners, Paragon Pain & Rehabilitation, LLP and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation or follow up visit. I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult or follow up visit is done through a two-way video link-up whereby the physician or other health provider at Paragon Health Partners can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or video-conference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering. If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by Paragon Health Partners.
10. I understand this consent covers my intital evaluation and all follow up visit with providers at Paragon Health Partners.
11. If you are a resident of Oklahoma you are required to have an in person visit in the office before you follow up visits can be completed via telemedicine.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize Paragon Health Partners and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition. I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as "Agree" and I do not agree to any that I have initialed as "Decline."

Date:_____ **Time:**_____ **AM/PM**

Signature: _____

Revised May 7, 2022