Name: _____Date of birth: _____ Age: _____ Today's Date: ___/___/___
Phone: (_____) _____ - _____ Email: _____@_____
Family Doctor _____ Phone _____ Fax _____ Can we send a letter to your
MD Address: (include city and zip)_____ doctor about your program?
Did your doctor refer you to CONCI? Yes No (If no: I heard about Conci _____) Yes No

Please complete the information below as completely as you can.

Have you ever had: (your occupation _____)

Y N ☐ High blood pressure ☐hypertension
Y N ☐ High cholesterol ☐elevated triglycerides ☐hyperlipidemia
Y N ☐ High blood sugar ☐diabetes ☐abnormal glucose tolerance ☐hypoglycemia
Y N ☐ Heart murmur ☐irregular heart beat ☐flopping of heart ☐palpitations
Y N ☐ Heart attack ☐stroke ☐congestive heart failure ☐angina
Y N ☐ Blood clots in the legs or lungs ☐DVT ☐pulmonary embolism
Y N ☐ Gout ☐arthritis ☐painful joints ☐back problems
Y N ☐ Sleep apnea ☐excessive snoring ☐fatigue ☐morning headaches
Y N ☐ Heartburn ☐reflux esophagitis ☐hiatal hernia
Y N ☐ Stomach ulcers ☐gall bladder disease
Y N ☐ Diverticulosis ☐bleeding from bowels ☐irritable bowel syndrome
Y N Any allergy to ☐milk ☐eggs ☐trouble digesting milk
Y N ☐ Any liver or kidney disease
Y N ☐ Frequent headaches ☐migraine headaches
Y N Females: Are you ☐breastfeeding now ☐pregnant now
Y N Do you have a history of ☐drug ☐alcohol ☐substance abuse
Y N Do you have a history of ☐an eating disorder ☐bulimia ☐anorexia nervosa
Y N Do you have ☐depression ☐anxiety ☐bipolar disease ☐schizophrenia

List any medical problems not listed above: _____

_____

YOUR FAMILY AND PERSONAL MEDICAL HISTORY

	You	mom	dad	siblings	grandparents	maternal	paternal
High blood pressure	____	____	____	____		____	____
Cancer	____	____	____	____		____	____
Mental illness	____	____	____	____		____	____
Diabetes/weight	____	____	____	____		____	____
Stroke/seizures	____	____	____	____		____	____
Respiratory disorder	____	____	____	____		____	____
Heart disease (CHF)	____	____	____	____		____	____
Other _____	____	____	____	____		____	____

SOCIAL HISTORY

marital status: M S D W student
cigarettes: yes no amount/d_____
alcohol: yes no amount/wk____
illicit drugs: yes no
residence: own home rent
live with parents/caregiver/roommate
education - completed high school 1-2-3-4
trade school college 1-2-3-4 post grad
occupation: _____

Last 4 times in hospital	1	2	3	4
Type of operation/illness				
Month and year hospitalized				

OFFICE USE ONLY **********

1st Part →Date _____ Ht_____ Wt_____ BP_____ Pulse_____ BMI_____ Body Gem_____ Body fat % _____ BDI____
Goal wt. _____ Waist Cirr. _____ UA: BLOOD =_____ KETONE=_____ GLUCOSE=_____ PROTEIN=_____ PH=_____

PEx: HEENT NECK LUNGS HEART ABD EXT. NEURO SKIN BREAST

Weight _____ BP _____ Pulse _____

Lab _____

EKG:_____

DR signature_____ Date _____

Plan _____

Problem List

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

LAST NAME_____FIRST NAME_____ MID INIT_____

ADDRESS_____CITY, STATE, ZIP_____

HOME PHONE_____ CELL PHONE_____

BIRTHDAY_____/_____/_____ SEX: M F RELATIVE NAME/PHONE_____

SOCIAL SECURITY NUMBER_____ - _____ - _____EMAIL ADDRESS_____

EMPLOYER_____WORK PHONE_____

EMPLOYER ADDRESS_____

OCCUPATION_____

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of policy holder:	_____	_____
Insurance company:	_____	_____
Address:	_____	_____
Policy number:	_____	_____
Group number:	_____	_____

*If the insured is not the primary carrier of the insurance please give the primary insurer's date of birth and ss# below.

_____

I UNDERSTAND THAT **I AM RESPONSIBLE** FOR PAYMENT OF FEES INCURRED AT THE CENTRAL OHIO NUTRITION CENTER REGARDLESS OF WHETHER MY INSURANCE REIMBURSES SERVICES (including but not limited to the $177 for the body composition, materials fee, and initial nutritional consultation at the first part physical).

I UNDERSTAND THAT **I AM NOT ALLOWED** TO RETURN ANY OPTIFAST ONCE IT HAS BEEN PURCHASED.

I UNDERSTAND THAT **I AM RESPONSIBLE** FOR PROVIDING CENTRAL OHIO NUTRITION CENTER WITH UPDATED INSURANCE INFORMATION SUCH AS CHANGE OD INSURANCE PROVIDER, CHANGE IN CO-PAY ETC. AND I AM RESPONSIBLE FOR ANY FEES INCURRED DUE TO LACK OF NOTIFICATION.

IF I RECEIVE INSURANCE REIMBURSEMENT **I HERBY ASSIGN** MY INSURANCE BENEFITS TO BE PAID TO THE CENTRAL OHIO NUTRITION CENTER. **I AUTHORIZE** CONCI TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY. I ALSO AUTHORIZE CONCI TO RELEASE INFORMATION REQUESTED BY ANOTHER PHYSICIAN IN REGARDS TO MY CARE.

I UNDERSTAND THAT IF I DO NOT CALL OR SHOW UP EACH WEEK FOR THE DURATION OF MY SPECIFIC PROGRAM THAT I WILL BE CHARGED A $25 **NO SHOW FEE**.

I UNDERSTAND THAT IF I HAVE A **RETURNED CHECK** THAT I WILL HAVE TO PAY THE $30 FEE ASSOCIATED WITH THAT.

I HAVE RECEIVED AND READ THE **CONCI HIPPA FORM** THAT WAS GIVEN TO ME AND HAVE HAD A CHANCE TO ASK QUESTIONS ABOUT IT.

SIGNED_____DATE_____

WITNESS_____DATE_____

MEDICATION LIST

It is very important to keep all of your health care providers informed of any medications, supplements, vitamins, etc., that you take so that we can provide you with the best care possible.

Your Name: _____ Date of Birth: _____

Please list your preferred pharmacy with phone number and location:

_____

Fill in the list below with any prescription medications that you take on a regular or as needed basis. Please do not write in the spaces that say "Doctor's Use Only."

Today's Date	Medication Name	Dosage Amount (mg, mL, units, etc.)	Times per Day	**Doctor's Use Only Today's Date**	**Doctor's Use Only Change In Dosage or D/C**

Please fill in the table below with any supplements, vitamins, or OTC medications that you use on a daily or regular basis:

Today's Date	Medication Name	Dosage Amount (mg, mL, units, etc.)	Times per Day	**Doctor's Use Only Today's Date**	**Doctor's Use Only Change In Dosage or D/C**

Do you have any known drug allergies? **Yes ☐** **No ☐** (If yes, please list them below.)

_____

_____

CONCI PROGRAM UTILIZATION STATEMENT

My name is _____. I have chosen CONCI's programs/services for the following reasons.

(Please check one)

_____ 1. Medical/Physical reasons

_____ 2. Cosmetic weight loss

If you have selected Medical/Physical reasons to use CONCI services, please list the medical conditions or physical ailments that have caused you to select our services, and/or describe the hope for medical benefits from utilizing our services.

1. _____
2. _____
3. _____
4. _____

Please use the space below for any comments or statements you wish to add to the above descriptions of why you want or need to use one of the programs offered by the Central Ohio Nutrition Center Inc. Please sign and date at the bottom of this statement of intention.

Signature _____Date_____

BECK INVENTORY

NAME_____DATE_____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement that best describes the way you have been feeling in the **past week**. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1) 0 I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad or unhappy that I can't stand it

2) 0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless and that things can't improve

3) 0 I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life all I see is failures
3 I feel I am a complete failure as a person

4) 0 I get as much satisfaction out of things as I used to
1 I don't enjoy things as I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied and bored with everything

5) 0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time
3 I feel guilty all the time

6) 0 I don't feel I am being punished
1 I feel I may be punished
2 I expect to be punished
3 I feel I am being punished

7) 0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted with myself
3 I hate myself

8) 0 I don't feel I am any worse than anybody else
1 I am critical of myself for my weaknesses or mistakes
2 I blame myself all the time for my faults
3 I blame myself for everything bad that happens

9) 0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself but would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance

10) 0 I don't cry anymore than usual
1 I cry more now than I used to
2 I cry all the time now
3 I used to be able to cry but now I can't cry even though I want to

11) 0 I am no more irritated now than I ever am
1 I get annoyed or irritated more easily than I used to
2 I feel irritated all the time now
3 I don't get irritated at all by things that used to irritate me

12) 0 I have not lost interest in other people
1 I'm less interested in other people than I used to
2 I have lost most interest in other people
3 I have lost all my interest in other people

13) 0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty making decisions now
3 I can't make decisions at all any more

14) 0 I don't feel I look any worse than I used to
1 I'm worried that I'm looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly

15) 0 I can work about as well as before
1 It takes extra effort to get started with things
2 I have to push myself very hard to do anything
3 I can't do any work at all

16) 0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up early & it's hard to get back to sleep
3 I wake up quite early and can't get back to sleep

17) 0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything

18) 0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

19) 0 I haven't lost much weight if any lately
1 I have lost more than 5 lbs. I am trying to lose
2 I have lost more than 10 lbs by eating less
3 I have lost more than 15 lbs

20) 0 I am no more worried about my health now
1 I am worried about physical problems such as aches and pains or upset stomach or constipation
2 I am very worried about my physical problems and it is hard to think of much else
3 I am so worried about my physical problems that I can't think of anything else

21) 0 I have not noticed any recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost complete interest in sex

PATIENT LIFESTYLE INVENTORY

NAME _____

LIST 3 OR MORE REASONS OF WHY YOU WANT TO LOSE WEIGHT

_____
_____
_____

LIST YOUR GOALS IN TREATMENT FOR OBESITY

_____
_____
_____

LIST SOME OF YOUR EXPECTATIONS

_____
_____
_____

BIOLOGICAL INFORMATION

Weight History

1. When did you begin to have a weight problem?
   _____ childhood onset _____ adolescent onset _____ gradual adult onset _____sudden adult onset

2. Have you ever been at a weight that you have felt comfortable? Y N weight _____ age _____

3. What has been your usual weight range for the past 5 years? _____

4. What was your lowest adult weight? _____ age _____

5. What was your highest adult weight? _____ age _____

6. What would you consider a realistic weight for you? _____

Family History

1. In your opinion, is anyone in your family 50 lbs or more above their "ideal body weight?" Y N
   If so, place a check mark next to the appropriate relative(s).

_____ maternal grandparents	_____ aunt(s)	_____ paternal grandparents
_____ parent(s)	_____ uncle(s)	_____ children
_____ spouse	_____ sibling(s)	_____ cousin(s)

2. Are any of your family members overweight by 50 lbs or less? Y N

3. Describe family attitudes toward food and eating while you were growing up.

_____

_____

_____

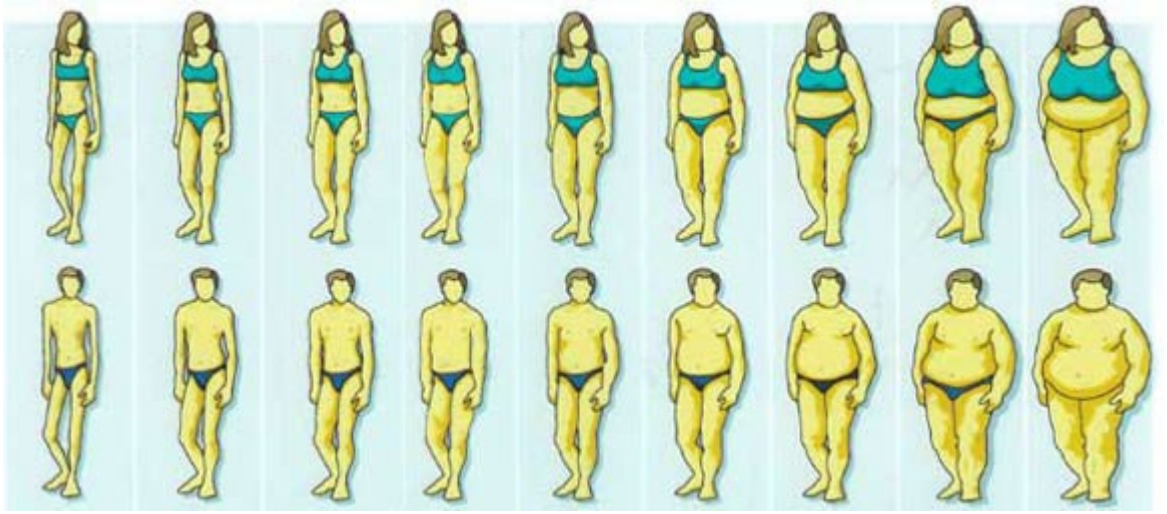
_____

Medical Information

Please identify family members who have had the following:

	Paternal grandparents	Maternal grandparents	Parents	Anut (if obese)	Uncle (if obese)	Spouse	Siblings	Children
Stroke								
Congestive heart failure								
Heart attack								
Kidney failure								
Diabetes								
Gall bladder disease								
Gout								
High blood pressure								
Aniema								
Malignancies								

Body Image



1 2 3 4 5 6 7 8 9

1. Using the diagram, which number best illustrates your weight today? _____
2. Using the diagram, which number best illustrates the weight you would like to achieve? _____

Diet History

1. Have you ever tried the following to lose weight?

Y	N	Weight Watchers	Y	N	Hypnosis
Y	N	Supervised diet plans	Y	N	Group therapy
Y	N	Self prescribed diets	Y	N	Pills
Y	N	Registered Dietitian consults	Y	N	Shots
Y	N	Adkins or low carb or low fat	Y	N	"Fasting"
Y	N	Liquid diets	Y	N	Eating disorders

2. Your dieting and previous experiences
   * Maximum amount of weight loss _____ pounds
   * Length of time to achieve weight loss _____ months
   * Length of time weight was kept off _____ months
   - What method of dieting if any did you find most successful? _____
   - What usually interferes with your weight loss program? _____
     _____

Psychological Information

1. Have you ever been counseled by a psychiatrist or psychologist for your weight problem? YES NO
2. When dieting do you have problems with depression? YES NO
3. Do you "binge" on food? YES NO
   - If you are a binge eater please describe a "typical binge." _____
     _____
   - How often do you binge?
     _____
   - Have you ever purged after bingeing? YES NO
   - Have you ever used laxatives after a binge? YES NO
   - Have you ever used diet pills after a binge? YES NO
4. How would you rate your self-esteem using the scale below?

LOW DEGREE _____ MODERATE _____ HIGH DEGREE
1 2 3 4 5 6 7 8 9 10

Additional Information

1. Please check all items that have contributed to your weight problems.

_____ Negative emotions and boredom	_____ Dining out frequently
_____ Social occasions	_____ Eat too often
_____ Food cravings	_____ Not hungry
_____ Positive emotions	_____ Inappropriate quantities of food
_____ Lack of exercise	_____ Physical problems
_____ Metabolic problems	_____ Eating "on the run" and fast food

_____ Other _____

2. Physical activity
   * Do you exercise on a regular basis? YES NO
     If so what do you do for exercise, how often, how long?
     _____
   - What type of recreational activities do you enjoy? _____
     _____
     _____

3. Social support

What kinds of support do you expect from the following individuals? Please circle the most appropriate answer.

SPOUSE	very good	fair	very little	sabotage
PARENTS	very good	fair	very little	sabotage
CHILDREN	very good	fair	very little	sabotage
SIBLINGS	very good	fair	very little	sabotage
FRIENDS	very good	fair	very little	sabotage
CO-WORKERS	very good	fair	very little	sabotage

4. Food intake

How many times per week do you eat the following meals away from home…and where do you usually eat out?
For example: cafeteria, fast food, restaurants, take out, delivery foods, others houses…etc.

MEAL	# TIMES PER WEEK	WHERE
BREAKFAST		
LUNCH		
DINNER		
SNACKS		

5. Please write down everything you ate in the past 24 hours.

_____

_____

_____

_____

_____

_____

_____

Name _____ **Date** _____

Personal Views (on exercise)

1. On a scale of 1-10 (1 being the worst) how would you rate your well being right now compared to 3-4 months ago?

1	2	3	4	5	6	7	8	9	10

2. Walking on level ground, do you get short of breath when you go: (average block 100 yards)

More than 5 blocks	Up to 5 blocks	1-2 blocks	Less than 1 block

3. Walking on level ground do you become fatigued after:

More than 5 blocks	Up to 5 blocks	1-2 blocks	Less than 1 block

4. Do you characterize your walking as:

Brisk	Normal	Slow

5. How many flights of stairs can you climb comfortably?

More than 2	2	1	Less than 1

6. Are you short of breath when you are at rest (for example in a chair or on a sofa or bed? YES NO

7. Do you awaken during the middle of the night due to shortness of breath? YES NO

8. In the last 3-4 months, what changes have you noticed in your ability to exercise?

Improved	No change	Deteriorated

9. Did you notice any of the following last month? (0=no 1=very little 2=some 3=moderately 4=often 5=very often)

	0	1	2	3	4	5
• swelling of ankles, feet, or legs	___	___	___	___	___	___
• feeling tired, fatigued, or low energy	___	___	___	___	___	___
• difficulty in walking about or climbing stairs	___	___	___	___	___	___
• shortness of breath	___	___	___	___	___	___

the Central Ohio Nutrition Center, inc. CONCi
648 Taylor Road, Gahanna, OH 43230
(614) 864-7225

INFORMED CONSENT

VERY LOW CALORIE DIET PROGRAM (VLCD)

WHAT WE WANT YOU TO KNOW…

When you decided to learn more about the OPTIFAST Program you took an important step toward improving your health. The Program can help you develop comprehensive weight management skills while you lose a medically significant amount of weight.

YOUR ROLE…

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of medical treatment. You must be willing to:

- Devote time needed to complete the assessment, treatment, and maintenance phase of The Program.
- Provide honest answers to questions about your health, weight problem, and eating activity and lifestyle patterns so that we can better understand how to help you.
- Work with us to manage your weight loss, including keeping a daily diary, attending group and individual sessions, having blood tests taken when deemed necessary by the Program physician, and following the diet and exercise prescription.
- Allow us to share information with your personal physician when the Program physician asks you to.
- Avoid strenuous exercise early on the VLCD except as approved by the Program physician.

If you do not have a personal physician we can assist you in finding one. Your signature below represents your permission, understanding, and commitment.

POTENTIAL BENEFITS…

Medically significant weight loss can:

- Lower blood pressure, reducing the risk of hypertension.
- Lower cholesterol, reducing the risk of heart and vascular disease.
- Lower blood sugar, reducing the risk of diabetes.

Edward J Baltes, M.D.
Richard Lutes, M.D.
Robert K. May, M.D.
J. Thomas Broyles, M.D.
Judy F. Loper Ph.D., R.D.

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves.

Other benefits may also be obtained. Increasing activity level favorably affects the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits as will.

POSSIBLE SIDE EFFECTS…

When you reduce the number of calories you eat to a level lower than the number of calories your body uses up during the day, you lose weight. In addition, your body makes some other adjustments in physiology. Some of these are responsible, in some participants, for rapid improvement in blood pressure and blood sugar; other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, slower heart rate, dry skin, brittle nails, rash, fatigue, diarrhea or constipation, muscle cramps, bad breath, change in menstrual pattern, are reduced, the more pronounced these responses may become, These responses are temporary and resolve when calories are increased after the period of weight loss. It is important to inform the staff of these side effects when they occur.

Other unusual , but temporary, side effects can include numbness or weakness in the lower leg due to excessive crossing of the leg during weight loss; allergic reactions to liquid diet ingredients, changes in sleep patterns; altered perception of body image, and changes in mood. Individual symptoms of depression on the whole tend to be improved, though less commonly, they may worsen.

Report any side effects or other conditions immediately to the program physician or to your personal physician.

POSSIBLE RISKS…

A medically significant amount of excess weight, when complicated by other diseases, such as diabetes, hypertension and coronary disease, measurably increases an individual's risk of sudden death. Sudden deaths have occurred during medically supervised weight reduction, though no cause and effect relationship with the diet has been established. Another risk- the risk of regaining weight- can only be reduced through long-term changes in diet and lifestyle. Some health professionals have noted an increase in binge eating after weight loss, though the casual relationship with this form of diet has not been established.

Not following the diet can have serious consequences. Failure to consume all of the packets of food or taking a diuretic medication (water pill) may cause low blood potassium level or inadequacies in other key nutrients. Low potassium level can be associated with serious heart irregularities, muscle cramps, and weakness.

When someone has been on a low calorie diet, a rapid increase in calorie intake (as can happen when someone overeats or binges) can be associated with bloating, fluid retention, disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the prescribed gradual increase in calories after weight loss is essential.

If you become pregnant, report this immediately. Your diet must be changed promptly to avoid further weight loss because a restricted calorie diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss, if you are sexually active, obesity is sometimes associated with infertility and weight loss can improve fertility under these conditions, so being infertile in the past may not provide protection against becoming pregnant during weight loss.

A WORD ABOUT GALLSTONES…

As body weight and age increase, so do the chances of developing gallstones. Those chances double for women, women using estrogen, and smokers. In a study of more than 1400 OPTIFAST Program participants, 1 in 100 developed symptomatic gallstones (requiring clinical evaluation or surgery.)

Losing weight, especially rapidly, may increase the chances of developing small stones or sludge within the gallbladder. Published reports have shown an increased rate of gallstone formation in individuals consuming VLCDs or losing weight rapidly. Gallbladder problems (stone, sludge, or inflammation) may require surgery to remove the gallbladder, and less commonly, may be associated with more serious complications such as pancreatitis or infection in the bile ducts, or even death.

A prescription drug (Actigall) is currently available which may help prevent gallstone formation during rapid weight loss. You may wish to discuss Actigall with the management physician.

Should any symptoms develop (the most common are fever, nausea, and cramping pain in the right upper abdomen) or if you know or suspect that you may already have gallstones, advise the program's physician.

YOUR RIGHTS AND CONFIDENTIALITY…

You have the right to withdraw from treatment without penalty, though you have a responsibility to ensure that your personal physician is able to assume medical care for you as you leave the program.

Data regarding your treatment results may be reviewed by scientists and epidemiologist's for research purposes only, and you may be contacted in the future by scientists to see how your health has been affected by your participation. All efforts will be taken to assure your confidentiality; however,

BY SIGNING THIS FORM…

1. You hereby agree to have the following medical procedures performed by the staff at the Central Ohio Nutrition Center:
    a. Blood test according to the medical protocol
    b. EKG after 50 lbs. weight loss, at 25 lbs. intervals or every 6 months (whichever comes first), or as deemed necessary by the physician.
2. You understand that photographs will be taken. They will be used only for medical records unless prior consent is given for their use elsewhere.

3. You understand that Nestle Nutrition Corporation and the clinic and clinical staff are not responsible for any harm or other injury you experience because you deviate from the program.

4. You accept financial responsibility for all bills incurred by you for services, tests, materials, and products on the OPTIFAST program.

5. You understand that we cannot take back any OPTIFAST® once it has been sold.

6. You understand the NO-SHOW policy, and that you are expected to attend weekly. You will be charged the office visit if you don't show. The exceptions to this policy are vacations, out of town for business, or illness. You must contact us if cannot attend.

I, the undersigned participant, have reviewed this information with one of the Program's health professionals and have had an opportunity to ask questions.

Patient_____ **Date:**_____ **Time:**_____

Program Representative_____ **Date:**_____ **Time:**_____

The Central Ohio Nutrition Center Inc.

AGREEMENT TO NOT RESELL PRODUCTS

Resale of OPTIFAST® Products…

The Nestle Nutrition products purchased through the OPTIFAST® weight management program, including OPTIFAST®, OPTITRIM®, and any other products associated with the program are intended to be sold and used **ONLY** through medically supervised weight management programs.

Resale of OPTIFAST® products only by OPTIFAST® providers and only to patients of OPTIFAST® clinics is an essential part of Nestle quality control procedures. Other sales, including sales on eBay, are in violation of clinic and patient agreements and infringe Nestle valuable rights in the OPTIFAST® trademarks. By signing this form, you agree that you will not resell any Nestle Nutrition products purchased through this weight management program.

Participant Signature _____ **Date** _____

Program Representative _____ **Date** _____

NOTICE OF PRIVACY PRACTICES
Effective Date April 14, 2003

CONCI Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, of PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

1. How we may use and disclose your PHI,
2. Your privacy rights in your PHI,
3. Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

B. If you have any questions about this Notice, Please contact:

Jody Riley, 1904 Bethel Road, Columbus, OH 43220, 614-451-1910

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to, our doctors and medical assistants- may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use or disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose you PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may use and disclose your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosures required by law. Our practice may use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose you PHI to public health authorities that are authorized by law to collect information for the purpose of: Maintaining vital records, such as birth and deaths, Reporting child abuse or neglect, preventing or controlling disease, injury, or disability, Notifying a person regarding a potential risk spreading or contracting a disease or condition, Reporting reactions to drugs or problems with products or devices, Notifying individuals if a product or device that they may have been using has been recalled, Notifying appropriate government agency (IES) and authority regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information, Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law, oversight activities can include, for example, investigations, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement, Concerning a death we believe has resulted from criminal conduct, Regarding criminal conduct at our offices, In response to a warrant summons, court order, subpoena or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator.

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) Use or disclosure involves no more than a minimal risk to your privacy based on the following (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver. The research could not practicably be conducted without access to and use of the PHI

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

<u>You have the following rights regarding the PHI that we maintain about you:</u>

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Jody Riley (451-1910) specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable request. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or heath care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family and friends. We are not required to agree to your request however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Jody Riley, 451-1910.

<u>Your request must describe in a clear and concise fashion:</u>
The information you wish restricted_____
Whether you are requesting to limit our practice's use, disclosure or both_____
To whom you want the limits to apply_____

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jody Riley, 451-1910, in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of your denial. Another licensed health care professional chosen by us will conduct this review.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing and submitted to Jody Riley, 451-1910. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you ask us top amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosure." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented. A- For example, the doctor sharing information with the nurse; or the billers using your information to file your insurance. In order to obtain an "accounting of disclosures", you must submit your request in writing to Jody Riley, 451-1910. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of the disclosure and may not include dated before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw you request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy o this notice, contact Jody Riley, 451-1910.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with out practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jody Riley, 451-1910. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Joy Riley, 451-1910.

I acknowledge I have had the chance to read CONCI'S NOTICE OF PRIVACY PRACTICES document as required by HIPAA.

Signature/Date_____