



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

ADAM Questionnaire about symptoms of low testosterone (Androgen Deficiency in the Aging Male)

Answer YES or NO to each of the following questions:		YES	NO
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

If you answer YES to number 1 or 7 or if you answer YES to more than 3 questions, you may have low testosterone.

Name: _____

Signature: _____

Date: _____



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Patient Informed Consent for B12 Injections

Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take B12.

All medications and supplements have potential side effects, including B12. Most people tolerate B12 without issue, side effects are rare. Potential common B12 side effects include but are not limited to mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

You acknowledge:

1. That if I begin to have side effects, I will contact Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C immediately and notify them of what is happening.
2. I understand that although rare, vitamin B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects include rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.
3. Before starting vitamin B12 injections I agree to make Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C, aware if I have any of these conditions: Leber's Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that has an effect on bone marrow, or drug/supplement allergies.
4. I understand that there could be interactions with B12 and certain medications/supplements.
5. The use of B12 on a weekly to biweekly basis without a documented B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.
5. Caution is advised while taking B12 if you have a sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for B12 injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release Perspective Health, Tammy Chesley FNP-C, Rebecca Lucas FNP-C, and the person injecting the B12 of any damages or liability if anything was to occur.

Name: _____

Signature: _____

Date: _____



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Male Informed Consent to Treat

I hereby give my consent to evaluation and treatment by Perspective Health, Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C for the following specified condition(s):

- Andropause or associated symptoms (Including testosterone replacement, manipulating hormone levels including DHEA and estradiol).
- Growth hormone abnormalities including decreased or suboptimal IGF -1, decreased or suboptimal Vitamin D-3 levels.
- Nutritional deficiencies, Overweight/Obesity, B12 injections and anything else the medical provider deems is necessary.

In addition:

- I acknowledge that treatment with testosterone, growth hormone stimulators, bioidentical hormone replacement therapy, B12, and thyroid optimization are considered off label use of the associated medications and have not been FDA approved for the use of health optimization, wellness, weight loss and/or for anti-aging purposes unless there is true medical necessity.

I agree to the administration of hormone replacement therapy, and/or nutritional supplements, and/or drugs designed to alter hormone levels which will meet my specific treatment objectives and to treat any specific diagnoses I might have.

Initial: _____

Alternative Treatments

I have been informed about alternative treatments and understand:

1. That we can leave the hormone levels alone.
2. We can use a natural approach such as weight loss and nutrition instead.
3. We can use alternative medications to increase your testosterone levels vs using prescription testosterone.

- I understand the alternative treatments and am choosing to consent to the treatment plan prepared for me by Perspective to address the condition/conditions listed above.

Initial: _____

Side Effects and Potential Risks

I acknowledge that common side effects of testosterone replacement are acne, possible balding, enlargement of the prostate, high blood pressure, high libido, enlargement of breast tissue (we will monitor and treat estrogen levels), testicular atrophy, fluid retention, infertility, and an increase in the thickness of your blood (hematocrit) due to the production of red blood cells (this will be monitored and treated if necessary).

I understand that the possible theoretical/possible side effects for men on testosterone replacement can be an acceleration in the growth of prostate cancer, elevations in hematocrit which could potentially predispose one to a blood clot, and cardiovascular disease including heart attacks, strokes, and blood clots.

Most of the common side effects resolve with time. Many of these can be treated by changing your testosterone dose and adding other medications.

I acknowledge that I should take extreme precaution if I am to use topical testosterone products. If a child or woman accidentally is exposed to the testosterone cream/lotion on my body, it could cause a significant increase in their hormone levels which could result in possible side effects.

Initial: _____

Safety of Hormone Replacement

Available data supports the safety of testosterone replacement therapy in men, and it is of the opinion of Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C that treatment is safe, but there remains controversy regarding the correlation between the use of testosterone replacement therapy and cardiovascular events such as but not limited to strokes, heart attacks, and blood clots. Some studies have shown correlations between testosterone replacement therapy and cardiovascular disease while others show no correlation or even a benefit in preventing cardiovascular disease.

I understand that close monitoring is required by all patients to minimize and prevent any possible risks. I understand that Perspective Health will monitor my blood work including hormone levels. I also understand that it is important to stay up to date with routine screening and health maintenance by my primary care provider to prevent and detect any possible life-threatening diseases or conditions.

I agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to, digital rectal exams, colonoscopies, cardiac screenings, and any other type of recommended health screenings. I agree to obtain these screenings through the direction of my primary care provider and will not hold Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and any additional Perspective Health staff responsible or liable for performing these health maintenance screenings or the treatment of any other conditions not relevant to my treatment goals with Perspective Health.

I want to initiate treatment at Perspective Health, and I give permission to Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and additional staff of Perspective Health to begin treatment without knowing results of age-appropriate and health maintenance screenings. In doing so, I release Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and other healthcare

practitioners of any claims of liability for cardiovascular events, prostate cancer, breast cancer, testicular cancer, and/or colon cancer. Further, I agree to immediately notify Perspective Health, Tammy Chesley, FNP- C, Rebecca Lucas, FNP-C, and additional staff of Perspective Health of any abnormal findings on any health screenings done by my primary care provider.

Initial: _____

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones and/or medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider or a specialist for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist in regard to any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at Perspective Health for the specific services Perspective Health offers. I acknowledge I am not wanting to establish primary care with Perspective Health, and I am here for specialized care including testosterone replacement, hormone restoration, etc.

I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with hormone restoration and treatment with Perspective Health. I release any claim in court or any type of complaint that could result from treatment with Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and any other staff associated with Perspective Health and will not hold liable any provider or staff of Perspective Health.

I understand that treatment modalities utilized by Perspective Health might not be supported by scientific/medical literature and could be seen as experimental or based on anecdotal claims. Many medical providers, including endocrinologists and urologists, might see these types of treatments as not medically necessary.

Initial: _____

Consent

I hereby authorize Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and additional staff of Perspective Health to evaluate and treat conditions that I have consented for. I consent to obtaining blood work before my initial evaluation so hormone levels can be monitored and appropriate treatment can be prescribed. I certify that I am signing this under my free will and am competent to make my own medical decisions.

Print Name: _____

Signature: _____ Date: _____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C, and their respective officers, directors, employees,

stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C medical providers employed by Perspective Health; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, of Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and Perspective Health; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C or Perspective Health. I am aware of the potential side effects associated with the above treatments, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name: _____

Signature: _____ Date: _____

Today's Date:	
Patient Information	
First and Last Name:	DOB:
Address:	
City:	State:
	Zip Code:
Cell Phone:	Home Phone:
Email:	
Occupation:	Employer:

Ethnicity: Please select all that apply				
Hispanic	Caucasian	African American	Asian	Other: _____

Health Insurance (if needed for lab work):	
Insurance Company:	
Policy ID #:	Group #:

Preferred Pharmacy:	
Pharmacy:	Cross Streets:

Marital Status:				
Single	Married	Divorced	Separated	Widowed

Gender:	
Male	Female

How did you hear about us? _____

Who is your Primary Care Physician? _____

Health History Questionnaire

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

Allergies	Reaction (i.e., hives, rash, anaphylaxis, etc.)

PLEASE LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS		
Medication	Strength	Use (i.e., 2 tablets twice a day)

HEALTH MAINTENANCE			
Exam	Date of exam	Exam	Date of exam
Recent labs		Physical exam	
Prostate exam		Echocardiogram	
Pap Smear		Colonoscopy	
Mammogram		EKG	
Dexa Scan		Eye exam	

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

MEDICAL HISTORY
Please mark the appropriate boxes to indicate if you have been diagnosed with any of the following

Neurology

- Stroke (CVA)
- Transient Ischemic Attack (TIA)
- Seizures/Epilepsy
- Dementia
- Parkinson's
- Migraine

Endocrine

- Thyroid Disorder
- Diabetes
- Elevated Cholesterol
- Osteoporosis

Cardiac

- Heart Attack
- Coronary Artery Disease
- Angina or Frequent Chest Pain
- High Blood Pressure
- Congestive Heart Failure
- Irregular Heartbeat
- Heart Murmur
- Rheumatic Fever

Lungs

- Asthma
- COPD (Emphysema)
- Sleep Apnea
- Valley Fever
- Tuberculosis

Urinary

- Enlarged Prostate
- Prostate Cancer
- Kidney Stones
- Kidney Failure
- Dialysis

Gastrointestinal

- GERD or reflux
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Crohn's Disease
- Diverticulitis
- H. Pylori
- Stomach Ulcer
- Pancreatitis
- Cirrhosis
- Hepatitis B
- Hepatitis C
- Colon Polyps
- Colon Cancer
- Barrett's Esophagus
- Lactose Intolerance
- Celiac Sprue
- Hiatal Hernia
- Hemorrhoids
- Gallbladder Disease

Rheumatology

- Osteoarthritis
- Gout
- Fibromyalgia
- Rheumatoid Arthritis
- Lupus

Blood

- Anemia
- Leukemia
- Lymphoma
- Bleeding Disorder
- Blood Transfusion
- HIV/AIDS

Circulation

- DVT
- Pulmonary Embolism
- Peripheral Vascular Disease
- Carotid Artery Disease

Psychiatric

- Anxiety Disorder
- Depressive Disorder
- Bipolar Disorder
- Schizophrenia

Please list any SURGERIES or PROCEDURES you have had:

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

FAMILY MEDICAL HISTORY

Adopted If you are adopted and you do not know your family medical history, please check this box and skip the rest of this Family Medical History section.

	Mother	Father	Sister(s)	Brother(s)
Living				
Deceased				
Age at death	_____	_____	_____	_____

	Mother	Father	Sister(s)	Brother(s)	Other
Alcoholism					
Alzheimer's					
Blood Disease					
CAD					
CHF					
COPD/Emphysema					
Stroke					
Depression					
Diabetes					
Heart Attack					
High Cholesterol					
Irritable Bowel					
Mental Illness					
Obesity					
Osteoporosis					
Vascular Disease					
Kidney Disease					
Seizure Disorder					
Other:					

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

WOMEN ONLY: GYNECOLOGY & PREGNANCY

Age of first menses: _____ Date of last menses: _____ Duration of flow: _____ days

Heavy Flow? Yes No N/A

PMS? Yes No N/A

Abnormal Discharge? Yes No

of pregnancies: _____ # of miscarriages: _____

Are you currently pregnant? Yes No

Are you currently trying to become pregnant? Yes No

TESTOSTERONE MEDICAL HISTORY & REVIEW OF SYSTEMS
Please mark the appropriate boxes to indicate if YOU or a FAMILY MEMBER have EVER been FORMALLY diagnosed by a medical provider with any of the following conditions

	Self	Blood relative (list relation)
High Blood Pressure	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	_____
Coronary Artery Disease	<input type="checkbox"/>	_____
History of Blood Clots	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	_____
BPH (enlarged prostate)	<input type="checkbox"/>	_____
Have you ever been on testosterone replacement therapy?	<input type="checkbox"/>	Yes No

Please mark the appropriate boxes to indicate if you have ever experienced the following conditions or medical evaluations

	Yes	If yes, please explain:
History of kidney, bladder, or prostate infections	<input type="checkbox"/>	
History of testicular trauma	<input type="checkbox"/>	
History of head trauma	<input type="checkbox"/>	
History of referral to Cardiology	<input type="checkbox"/>	

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

NEUROPSYCHOLOGICAL

Have you ever received psychiatric treatment?	Yes	No
Have you ever considered or attempted suicide?	Yes	No
Do you have nervous habits?	Yes	No
Are you on any antipsychotic medications?	Yes	No
Do you ever experience episodes of mania?	Yes	No

SOCIAL HISTORY

Sex	Are you currently sexually active?				
	Yes		No		
Caffeine	None	Coffee	Tea	Soda	Energy Drinks
	If yes, how many caffeinated drinks do you have in an average day? _____				
Alcohol	None	Beer	Wine	Liquor	
	If yes, how many alcoholic drinks do you have in an average week? _____				
Tobacco	Never smoked				
	Current smoker: packs/day _____ # of years _____				
	Former smoker: packs/day _____ # of years _____				
	Current chewing tobacco: # of years _____				
	Former chewing tobacco: # of years _____				
Marijuana	Never				
	Vape	Edibles	Flower		
	Medical	Recreational			
	If yes, how often do you use marijuana?				
Drugs	Do you have a history of recreational drug use?		Yes	No	
	Have you ever used needles to inject drugs?		Yes	No	



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Informed Consent for Peptide Therapy

Please initial each point acknowledging you have read and understand each one:

Peptides are amino acids that have biological activity which mimic certain hormones within the body. Peptides have the ability of increasing certain naturally producing hormones within the body to illicit a certain effect which will be discussed by Perspective Health. Certain peptides are FDA approved for the treatment of various diseases while other peptides are investigational new drugs that are not FDA approved to be marketed for consumption in humans even though clinical trials have shown them to have a favorable safety profile.

Initial: _____

Peptide therapy for the purpose of preventative care, weight loss, performance enhancement, anti-aging, and any additional condition discussed by Perspective Health is considered by the FDA to be "off-label use."

Initial: _____

Peptide therapy can be administered either orally, subcutaneously, intramuscularly, intravenously, or intranasally. The various preparations will be discussed with me by Perspective Health.

Initial: _____

Peptide therapies being administered by Perspective Health are prepared by registered compounding pharmacies that comply with all state and federal regulations.

Initial: _____

I acknowledge that Perspective Health is not responsible for any manufacturing issues related to peptides prepared by compounding pharmacies and that the sole responsibility for sterility, potency, and safety lie with these pharmacies.

Initial: _____

I understand that peptide therapies are not necessarily approved for my medical conditions, and they are not a medical necessity, rather, they are an adjunctive and complimentary therapy to my treatment plan. Therefore, I acknowledge that it is an elective treatment option.

Initial: _____

(WOMEN ONLY) There has been little research regarding the safety of peptide therapy in pregnant and breast-feeding women. I certify that I am not pregnant nor plan on becoming pregnant while on peptide therapy.

Initial: _____

I understand that with any drug, peptide therapies can carry potential side effects, including but not limited to:

Rash, fever, nausea, vomiting, allergic reactions, decreased insulin sensitivity, flushing, headache, fatigue, lightheadedness, abdominal cramping, joint pain, fluid retention, and additional side effects not listed that will be discussed during your evaluation with Perspective Health.

Initial: _____

I understand that alternatives to peptide therapy are:

- Doing nothing
- FDA approved standard medication treatments
- Referral to specialists.
- Surgery

I acknowledge that there are no guarantees relating to the efficacy of peptide therapies and that Perspective Health is not responsible for my individual performance and ability to also exercise and diet.

Initial: _____

I certify that I will notify Perspective Health immediately if I have any concerns or side effects.

Initial: _____

I certify that I have had the risks and benefits discussed with me about peptide therapy and that I have had all my questions and concerns answered to my satisfaction by Perspective Health.

Initial: _____

I hereby voluntarily consent to be evaluated and treated by Perspective Health with the goal of improving my health, performance, and possibly delaying the effects of aging through peptide therapies.

Initial: _____

Name: _____

Signature: _____

Date: _____



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Patient Informed Consent for Medical Weight Loss with the use of Phentermine

If applicable, and if deemed medically qualified and appropriate, I hereby authorize Perspective Health to assist me in my weight reduction efforts. I understand that my treatment program consists of a balanced diet, a regular exercise program, instruction in behavior modification techniques, possibly meeting with a registered dietician, and the use of the appetite suppressant medication Phentermine. I also understand that regular medical visits will be necessary while on the medication and that Phentermine must be used with caution and under direct supervision of Perspective Health.

Risk of proposed treatment: I understand that any medical treatment may involve risks as well as the proposed benefits of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risk. Risks of Phentermine include but are not limited to nervousness, diarrhea, constipation, sleeplessness, headache, tremor, fever, fainting, dry mouth, rash, change in libido, difficulty urinating, shortness of breath, swelling of feet or ankles, tiredness, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, hallucinations, stomach cramps, high blood pressure, palpitations, arrhythmias, rapid heart rate, and gallstones. Although seen only in rare cases, pulmonary hypertension, or heart valve disease may develop. The latter two conditions are serious and can be fatal. In case of serious side effects, stop taking the Phentermine and seek immediate medical assistance. In addition, Phentermine can be addictive and should not be used with a history of drug dependence. I also understand that there are certain health risks associated with remaining overweight or obese including high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, sleep apnea, and sudden death.

I further understand that Phentermine should not be used by people who suffer from heart disease, glaucoma, history of a stroke, liver or kidney disease, those with a history of drug dependency, alcoholism, psychotic illness, uncontrolled hypertension, advanced atherosclerosis, thyroid overactivity, people who are on MAOI's, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medications: Decongestant medications (Sudafed/Pseudoephedrine, Tylenol Sinus, Claritin D, Zyrtec D and Allegra D), Stimulant medications, high doses of caffeine, other weight loss medications, ephedrine MAO inhibitors, alcohol, antipsychotic medications, and thyroid medications.

Patient responsibility: As the patient, I understand it is my responsibility to follow instructions carefully, and to report to Perspective Health any significant medical problems that I think may be related to my weight control program as soon as possible. I agree to notify Perspective Health of any medical problems that I may have, or any results of labs/tests ordered and reviewed by any other physician. I further acknowledge that I enter this program in full knowledge and understanding that no physician, advanced practice provider, or staff of Perspective Health has prior knowledge as to whether I would or would not have adverse effects since each individual has a different biological and chemical makeup. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive Phentermine will be dependent on my progress in weight reduction and weight maintenance. I understand that a balanced caloric intake combined with regular exercise without the use of Phentermine may likely prove successful if followed, even though I would be hungrier than without the suppressant.

I am also in full understanding that Phentermine will be used no longer than 3 consecutive months. After 3 months of use the medication will be discontinued. If you and Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C agree to use the medication longer than 3 months or if your BMI has decreased below the Federal Drug Administration's recommended value you will be using the medication in an off-label manner.

Phentermine may result in lethargy or depression with abrupt discontinuation, and I understand that during the program, medications will be discontinued if:

- I become pregnant, try to become pregnant, or suspect that I am pregnant.
- I develop a contraindication or serious side effect of the medication.
- I do not comply with medical requirements, i.e., visits, med doses, etc.
- I fail to lose and/or maintain weight appropriately.
- I have a planned surgery. Medications are to be stopped at least 2 weeks prior to any surgical procedure requiring general anesthesia.

Women Only: I understand Phentermine should not be taken during pregnancy, due to the chance of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both Perspective Health and my OB/GYN immediately. In addition, Phentermine is not to be used while breastfeeding.

NO GUARANTEE: 1) UNDERSTAND THAT MUCH OF THE SUCCESS OF THE PROGRAM WILL DEPEND ON MY EFFORT, AND THAT THERE IS NO GUARANTEE THAT THE PROGRAM WILL BE SUCCESSFUL. 2) I UNDERSTAND THAT AN INDIVIDUAL WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL MY LIFE, IF I AM TO BE SUCCESSFUL LONG-TERM.

Patient Consent/Waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of the risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and Perspective Health from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment. I understand it is my responsibility to give the name of my primary care physician where labs and/or EKG can be obtained for follow through and interpretation, if need be.

WARNING: If you have any questions as to the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask Tammy Chesley FNP-C or Rebecca Lucas, FNP-C now before signing this consent form. To conclude, by signing this document you are agreeing to the risks associated with Phentermine. You are agreeing that to be successful in your weight loss goals you must alter your lifestyle and adopt healthy eating and exercise patterns. You are agreeing that you are not pregnant or breastfeeding. You are agreeing that you understand Phentermine may be addictive. You are agreeing that you must notify Perspective Health of any medical conditions current or that develop while taking Phentermine and you are agreeing that this document has been adequately explained to you and that you understand the document in its entirety.

I understand the risks associated with taking Phentermine and agree to take only as prescribed and report any adverse reactions immediately.

Name: _____

Signature: _____

Date: _____



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

HIPAA – Notice of Privacy Practices

Perspective Health is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Summary of Rights and Obligations Concerning Health Information

Perspective Health is committed to preserving the privacy and confidentiality of your health information which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Perspective Health. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- Plan your care and treatment;
- Provide treatment by us or others;
- Communicate with other providers such as referring physicians;
- Receive payment from you;
- Make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- Make you aware of services and treatments that may be of interest to you; and
- Comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have the right to:

- Ensure the accuracy of your health record;
- Request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
- Request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- Maintain the privacy of your health information;
- Provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of our most current *Notice of Privacy Practices*;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Disclosure of Your Health Care Information:

We may disclose your healthcare information as necessary to comply with State Workers Compensation laws, Public Health Authorities, Emergency Situations, Judicial & Administrative Proceedings, Law Enforcement, Medical Examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude for referrals, and change of ownership.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Name: _____

Signature: _____

Date: _____



Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Consent for Telehealth

This consent is for all telehealth services provided to me by Perspective Health. Please select the provider you are scheduled with today:

Tammy Chesley, FNP-C

Rebecca Lucas, FNP-C

Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators. Specifically, a health care professional will be communications with me remotely via the Internet using doxy.me web-based audio-video software (referred to in this form as Telehealth Appointment). Doxy.me only hosts the software and does not provide medical advice or information. This Telehealth Appointment may be for diagnosis, continuity of care, treatment, testing, or medical consultation deemed necessary by my Healthcare Provider or me.

I understand that during a Telehealth Appointment

- Details of my medical history and personal health information may be discussed with me and/or other health professionals
- Audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record
- All confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment
- Industry standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption
- There may be security and privacy risks associated with Internet-based communications
- There are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider.
- Either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate for diagnostic decision-making or for providing the care I desire.
- In addition to my Healthcare Provider named above, I will be informed of any other person who may be present during the appointment and have the right to have them leave the viewing and listening area.
- To maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment
- Due to the limitations of telehealth that are out of my control (such as an unreliable Internet connection), I will call local authorities (9-1-1) to assist me with a medical emergency
- I have the right to omit or withhold specific details of my medical history/physical examination

- that are personally sensitive
- My Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me
- The communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider

Therefore, by consenting to this Telehealth Appointment:

- I desire to engage in remote audio-visual communication with my Healthcare Provider
- I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed
- I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
- I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment
- I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider
- I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy
- If my questions are not answered to my satisfaction, I have the right to terminate the appointment
- I am at least 18 years of age

Name: _____

Signature: _____

Date: _____

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

DIET AND LIFESTYLE

Exercise	Sedentary (no exercise)
	Mild exercise (doesn't require increased breathing or sweating)
	Occasional exercise (regular exercise 1-3 times per week)
	Regular exercise (consistent regimen)
Diet	Do you follow a specific diet? Yes No
	If yes, please indicate: Vegan Vegetarian Other (please list):
	How many meals do you eat in an average day? _____

WEIGHT LOSS

What is your **current** weight? _____ What is your height? _____ft _____in

What is your **highest** weight? _____

What is your **lowest** weight? _____

What is your **goal** weight? _____

When did you first become overweight?

How did your weight gain start?

What do you think is the cause of your weight problem?

Have you ever stayed the same weight for 10 years or more? Yes No

Name:	DOB:	Today's Date:
--------------	-------------	----------------------

CONTRIBUTING FACTORS
Please check all boxes that apply to your weight gain

Slow Metabolism

Family History of Obesity

Comfort food dependency

Lack of exercise

Binge eating

Late night snacking

History of trauma

History of grief and loss

Medication related weight gain

Significant restrictive eating behaviors like anorexia

PRIOR ATTEMPTS

What was your most successful strategy for weight loss?

How much weight did you lose with that strategy?

How quickly did you regain the weight?

RESTFULNESS

Do you have problems falling or staying asleep?	Yes	No
How many hours a night do you sleep?		
Do you wake up feeling refreshed?	Yes	No
Do you have a low energy level?	Yes	No
Does your energy level affect your daily activities?	Yes	No