Pearls of Wisdom
Consulting Services, PLLC
Margie C. Sweeney, MD, OFS, CPC - Owner and CEO

Dear Patient,

Welcome to Pearls of Wisdom Consulting Services. I'm excited that you are committed to improving your health and have invited me to be part of your journey. My approach to the medical management of overweight and obesity is similar to that of other chronic diseases, like diabetes or high blood pressure. Treatment is tailored to your needs and may look different than someone else in this program. Additionally, I provide coaching to help you identify and overcome barriers to success.

I promise to provide compassionate care that is non-judgmental and sensitive to your needs. I am committed to your medical safety, particularly when prescribing anti-obesity medications, therefore, it is important that you are under regular care with a primary care provider and that you allow me to share your medical progress with your provider to ensure that you are receiving the best possible care. At times, it may also be necessary to communicate with your specialists regarding your weight management care. Included in this packet is an acknowledgement and release form requesting your signature.

Following are a few details to keep in mind:

- Your first visit will last 45-60 minutes and will entail a comprehensive evaluation. Lab work and an EKG will be ordered at this visit tailored to your medical needs. Please bring your completed New Patient Packet to your first visit. You will need to re-schedule if you do not have a completed packet. For your convenience, you can fax the completed packet prior to your scheduled appointment to 888-811-0641 which is a secure fax line for your HIPAA privacy. After your initial appointment you will be provided a link to enter the patient portal to view your records and to communicate securely regarding your health. Texting and email are not secure means of communication with your provider.
- Please bring your picture ID and your social security card to your first appointment.
- Subsequent visits will last 20-30 minutes and will entail review of food and activity logs, coaching, and medication management, if appropriate. It is important for your success in this program to bring your food and activity logs to each appointment.
- Payment for services is due and payable at time of service. Insurance will not be billed.
- Failure to keep appointments and bring logs to your scheduled appointments will diminish your ability to succeed in the program.
- Lost prescriptions will not be re-issued.

Weight loss and maintenance can be a challenging endeavor. I want to celebrate your successes and support you if you encounter difficult times.

Sincerely,

Margie C. Sweeney, MD, OFS, CPC

Margie C. Sweeney, MD, OFS, CPC
Owner and CEO
Pearls of Wisdom Consulting Services, PLLC

RULES FOR USE OF ANTI-OBESITY MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT DR. MARGIE SWEENEY 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 DR. SWEENEY DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Many anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Dr. Margie Sweeney will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform Dr. Sweeney at Pearls Wisdom Consulting Services, PLLC 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 contra-indicated with certain medical histories, allergies, or other medication use**. I agree that I will be completely honest in disclosing this information and will notify Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC 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 for the best health care outcomes, that Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC may need to from time to time consult with my primary care provider and/or specialists regarding my health and medications used.

I agree to take the medication as prescribed and directed by Dr. Margie Sweeney. I understand that taking medications in any way other than as directed and prescribed could be dangerous to my health. I also understand that medications are typically considered after a trial of failed weight loss with nutritional/behavior modifications. If I am deemed a candidate for the medication program at Pearls of Wisdom Consulting Services, PLLC, I am aware that the lowest effective dosage will be tried prior to increasing dosages.

I understand that medication prescriptions can be filled at a pharmacy of my choice. I agree to use only one pharmacy at a time to fill any scheduled anti-obesity prescriptions, and I give my permission for Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC to notify area pharmacies of the terms of this agreement.

I understand that prescriptions will not be re-written if lost, post-dated, or refilled before the appropriate time interval.

I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC.

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 Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC is an experienced specialist in obesity medicine who will, at times, elect/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 Dr. Sweeney at Pearls of Wisdom Consulting Services, PLLC as soon as possible.

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 an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that Dr. Margie Sweeney at Pearls of Wisdom Consulting Services, PLLC may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.

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

Patient Signature: _____ Date: ____/____/_____

PEARLS OF WISDOM CONSULTING SERVICES, PLLC
PO Box 470399 Celebration, FL 34747-7017 Telephone: 407-973-3366 Fax: 888-811-0641

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize Dr. Margie Sweeney to help me in my weight reduction efforts. I understand that my program may consist of a balanced, reduced-calorie diet, a regular exercise program, instruction on behavior modification techniques, and coaching. It may also involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with overweight and obesity. Risks of this program 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, increase or slowing of the heartbeat and heart rhythm irregularities, and risk of weight re-gain. These and other possible risks could, on occasion, be serious or even fatal.

Risks associated with remaining overweight or obese may include but are not limited to high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in food and activity habits and permanent changes in behavior to be treated successfully.

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)

_____ _____
Patient Signature Date
(or signature of person with authority to consent for patient)

_____
Witness (printed)

_____ _____
Witness Signature Date

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize Dr. Margie Sweeney at Pearls of Wisdom Consulting Services, PLLC to discuss my medical condition and/or treatment as specified below with the following individuals and health care providers listed below for the purposes or rendering the most safe, accurate, and complete medical care possible.

Name: _____ Relation to Patient: _____

Address: _____ (City) _____ (State) _____ (Zip) _____

Telephone: _____

Name: _____ Relation to Patient: _____

Address: _____ (City) _____ (State) _____ (Zip) _____

Telephone: _____

Name: _____ Relation to Patient: _____

Address: _____ (City) _____ (State) _____ (Zip) _____

Telephone: _____
(Please include any additional names on a separate page.)

1. The type and amount of information to be used or disclosed is as follows:
   - ▫ Complete health records
   - ▫ Lab results/X-ray reports
   - ▫ Physical exam
   - ▫ Consultation reports
   - □ Immunization record
   - ▫ Medications/allergies
   - □ Emergency/hospital records
   - □ Other (please specify): _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. (*This information may be disclosed to and used by Dr. Margie Sweeney at Pearls of Wisdom Consulting Services, PLLC for the purpose of facilitating my health care.)*

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Margie Sweeney. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: <u>one year from date of signature below.</u>

4. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, however, I am aware that for the best medical treatment, circumstances may arise for the need to discuss my care with my other health care providers and/or designated family/friends/etc. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Margie Sweeney at Pearls of Wisdom Consulting Services, PLLC.

_____

Patient's Name (printed)

_____ _____

Patient Signature Date

(or signature of person with authority to consent for patient)

_____

Witness (printed)

_____ _____

Witness Signature Date

PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: M F SSN:_____

Employment Information

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext. _____

In Case of Emergency

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Primary Care Provider: _____ Phone: _____

Referred by: _____

Financial Policy

Thank you for selecting Pearls of Wisdom Consulting Services, PLLC for your health care needs. I am honored to be of service to you. This is to inform you of my billing requirements and financial policy.

Please be advised that payment for all services is due and payable at the time services are rendered. For your convenience, VISA, MASTERCARD, check, and cash are accepted forms of payment.

Please be advised that insurance is not filed for services rendered at Pearls of Wisdom Consulting Services, PLLC.

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

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

_____ _____

Patient's Signature Date

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NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How is your weight affecting your life and health? _____
_____
_____

Weight History

When did you become overweight?
▫ Childhood ▫ Teens ▫ Adulthood ▫ Pregnancy ▫ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
▫ Stress ▫ Marriage ▫ Divorce ▫ Illness ▫ Medication abuse ▫ Travel ▫ Injury
▫ Nightshift work ▫ Insomnia ▫ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
▫ Weight Watchers ▫ Nutrisystem ▫ Jenny Craig ▫ LA Weight Loss ▫ Atkins
▫ South Beach ▫ Zone diet ▫ Medifast ▫ Dash diet ▫ Paleo diet
▫ HCG diet ▫ Mediterranean diet ▫ Ornish diet ▫ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):
▫ Phentermine(Adipex) ▫ Meridia ▫ Xenecal/Alli ▫ Phen/Fen
▫ Phendimetrazine(Bontril) ▫ Topamax ▫ Saxenda ▫ Diethylpropion
▫ Bupropion(Wellbutrin) ▫ Belviq ▫ Qsymia ▫ Contrave
Other: _____
What worked? _____
What didn't work? _____
Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ At what time of day/night do you eat breakfast? _____
Number of times you eat per day (including snacks): _____
Do you get up at night to eat? Y / N If so, how often? _____

Food triggers (check all that apply):
▫ Stress ▫ Boredom ▫ Anger ▫ Seeking Reward ▫ Parties ▫ Eating Out
▫ Fast Food ▫ Other: _____

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Food cravings:
▫ Sugar ▫ Chocolate ▫ Starches ▫ Salty ▫ High Fat ▫ Large Portions
Favorite foods: _____

Medical History
Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

▫ Heart attack	▫ Angina	▫ Gall bladder stones	▫ Sleep apnea
▫ High blood pressure	▫ Stroke	▫ Indigestion/reflux arthritis	▫ Thyroid
▫ High cholesterol	▫ Diabetes	▫ Celiac disease	▫ Anxiety
▫ High triglycerides	▫ Gout	▫ Pancreatitis	▫ Depression
▫ Infertility	▫ Polycystic Ovarian Syndrome		

▫ Cancer (type/s): _____
▫ Other _____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
▫ Gastric bypass ▫ Gastric banding ▫ Gastric sleeve ▫ Gall bladder ▫ Heart bypass
▫ Hysterectomy ▫ Other: _____

Medications/supplements (list all current medications/supplements, dosages, and # of times/day taken):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: (Medications/supplements)_____
_____
(Foods)_____

Social History
Smoking: ▫ Never ▫ Current smoker (_____ packs/day) ▫ Past smoker (quit _____ years ago)
Alcohol: ▫ Never ▫ Occasional ▫ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ▫ Never ▫ Current ▫ Past ▫ Type of drugs: _____
Marijuana: ▫ Never ▫ Current user (_____ times/day)

Family History

Obesity (check all that apply): ▫ Mother ▫ Father ▫ Sister ▫ Brother ▫ Daughter ▫ Son

Diabetes (check all that apply): ▫ Mother ▫ Father ▫ Sister ▫ Brother ▫ Daughter ▫ Son

Other (check all that apply): ▫ High blood pressure ▫ Heart disease ▫ High cholesterol

▫ High triglycerides ▫ Stroke ▫ Thyroid problems ▫ Anxiety ▫ Depression

▫ Bipolar disorder ▫ Alcoholism ▫ Cancer (type/s): _____

Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

▫ Recent weight loss more than 10 pounds

▫ Recent weight gain more than 10 pounds

▫ Acne	▫ Skin rash	▫ Cough
▫ Snoring	▫ Shortness of breath	▫ Chest pain
▫ Difficulty breathing when flat	▫ Fainting/Blacking out	▫ Palpitations
▫ Swelling ankles/extremities	▫ Abdominal pain	▫ Bloating
▫ Constipation	▫ Diarrhea	▫ Food intolerance
▫ Dysphagia/difficulty swallowing	▫ Indigestion	▫ Nausea/vomiting
▫ Increased appetite	▫ Decreased appetite	▫ Heartburn
▫ Gas and bloating	▫ Urinary frequency/urgency	▫ Slow urine flow
▫ Nighttime urination	▫ Blood in stools	▫ Back pain (upper)
▫ Back pain (lower)	▫ Joint pain	▫ Muscle aches/pain
▫ Dizziness	▫ Headaches	▫ Seizures
▫ Weakness/low energy	▫ Anxiety	▫ Depression
▫ Insomnia	▫ Memory loss	▫ Inability to concentrate
▫ Mood changes	▫ Nervousness	▫ Loss of interest
▫ Cold intolerance	▫ Excessive sweating	▫ Hair changes
▫ Heat intolerance	▫ Blood clots	▫ Fatigue/tiredness

(Women only)

▫ Absence of periods	▫ Hot flashes	▫ Change in bladder habits
▫ Abnormal/excessive menstruation	▫ Facial hair	

Comments: _____

_____

_____

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!

1._____

2._____

3._____

4._____

5._____

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

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

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How I Plan to Lose Weight

Goal setting is the “how” of weight loss. Motivators are the “why.” When setting goals, utilize the SMART technique:

SMART	Technique	Example
Specific	Who, what, where, when, how…	“I want to lose 10 pounds in two months.”
Measureable	How will you track?	10 pounds in 8 weeks = 1.25 pounds/week
Attainable	Resources you have available, previous experience	“I have been able to do this before, and now I have new tools from my doctor!”
Relevant	Why this goal is important	Review your motivators above
Timely	Set benchmarks and deadlines	“Focusing for two month intervals works for me.”

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