HCG Therapy

New Patient Package

Welcome to our program!

Confidentiality Statement

Your health is a serious personal matter and we understand that confidentiality is of the utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes. We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols, please contact us immediately.

Your privacy is important to us and we use every care to secure your privacy rights!

HIPAA: Health Insurance Portability and Accountability Act

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully.

In compliance with the 1996 Congressional act to protect the privacy of patients protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes.

Operations: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state of federal organization address and/or telephone numbers to file a complaint.

We will maintain a log for each patient we service, which will list what information was released and for what purpose. The patient has the right to review this log upon request.

____ _______________

Patient Signature Date

Health Evaluation/ Basic Exam

Patient Name:______________________________ Birthday:___/___/___ Sex:__ Male __Female

Address: ____

Home#____-____-______ Cell# ____-____-_____ Email:_________________________________

Family Physician:

____

Address: ____

Current Treatment and/or Medication Prescribed? ___Yes ____No If yes, Please Explain

____

____

____

____

Do you use tobacco? ____Yes ____No Frequency_______________ Quantity________________

Do you use Alcohol? ____Yes ____No Frequency _______________Quantity________________

Do you use Caffeine? ____Yes ____No Frequency _______________Quantity________________

	Yes	No
1. Have you ever consulted any medical practitioners for, or so far as you know, ever been treated for:		
A. Any disorder of eyes, ears, nose or throat, Including Speech impairment or loss of sight?	☐	☐
B. Any disease of the lungs or respiratory track such as tuberculosis, emphysema, pleurisy, asthma, hay fever, spitting blood, or persistent horsiness or coughing?	☐	☐
C. Any disorder of the heart or blood vessels, e.g. heart attack, angina, pectoris, stroke, palpitation, elevated blood pressure , shortness of breath, chest pain, irregular pulse or varicose veins.	☐	☐
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?	☐	☐
E. Any disorder of the prostate, bladder, kidneys or genitor-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic?	☐	☐
F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches?	☐	☐
G. Any impairment of function, or loss of hand, arm , shoulder, foot, leg, or hip, or back disorder?	☐	☐
H. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycernia, diabetes, glandular condition e.g., thyroid, hernia, skin disease or eczema?	☐	☐

	Yes	No
2. Have you ever:		
A. Had a surgical operation?	☐	☐
B. Been told to have an operation that wasn't performed?	☐	☐
C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram?	☐	☐
D. Lived with someone who has had T. B. in the last 2 years?	☐	☐
E. Had a weight change in the past year? If yes, reason? (List below)	☐	☐
F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces?	☐	☐
G. Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐
3. Other that previously stated, as far as you know, have you in the last 5 years:		
A. Had any illness, disease or injury?	☐	☐
B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc.?	☐	☐
C. Consulted any medical practitioner for any reason (including check-ups)?	☐	☐
D. Any reason to feel you are not in good health?	☐	☐
E. Are you taking any medication or drugs?		
4. For women only:		
A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below)	☐	☐
B. Any disorder of the breasts or female organs?	☐	☐

5. A. Family History

Family Record	Age if Living	Condition of Health If not "Good", give details	Age At Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide? ☐ ☐

6. Do you participate in regular exercise? ☐ ☐

If yes, describe type and frequency.

____

____

____

8. Remarks: Please give complete details for any questions answered YES above:

Question #:	Dates/Duration	Physicians Name, Hospital or Company, Address, Phone Nature of Condition, Treatment, Results, Reasons or Other Info

9. Basic Exam

Height____________Weight____________

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to Metro Medi Spa is correctly recorded, complete and true and I agree that the Company, believing them to be true, shall rely and act upon them accordingly. This physical exam is required so that our doctors have accurate current health information and that information is then reviewed by our medical staff along with testing results and health histories so that our doctors can properly review, qualify, and treat patients for all of our preventative health service and HCG therapy programs.

Dated at______________________on____________________________20______________________________

Signature of Patient____

MEDICAL CONDITION ADKNOWLEDGEMENT FORM AND DISCLAIMER FOR HCG THERAPY AND PROTOCOL

I herby understand and acknowledge that there are certain and specific disorders and /or medical conditions that prevent me from utilizing HCG therapy. These medical conditions could create severe medical adverse reactions and/or severe medical conditions.

I further understand and confirm that I have none of the disease and/or conditions listed below, which could lead to and/or cause a severe medical reaction or medical conditions.

1. Pregnancy
2. Auto immune Disorder
3. HIV
4. Lupus
5. Hashimoto Graves Disease that is uncontrolled
6. Uncontrolled Diabetes (A1C in excess of 7.0)
7. Coumadin Therapy 8. Any Cancer, active or inactive
8. Rheumatoid Arthritis
9. Uncontrolled Polycystic Ovarian Syndrome

I hereby acknowledge that I have read and understand the statements contained above and that these statements DO NOT apply to my current medical condition.

Signature Date

Print Name

Patient Authorization Agreement

All Nails LLC. (“Metro MediSpa”) providing the undersigned patient (“Patient”) with medical management, administrative and referral services. Patient acknowledges and agrees to the following terms and conditions contained in this Patient Authorization Agreement (“Agreement”). With this agreement, Patient submits with this agreement an accurately completed Medical History Form (“MHF”). Patient agrees to respond to truthfully, accurately and completely in completing the MHF or any agent completing the form and acknowledges that failure to provide truthful, accurate and complete information on the MHF could result in inappropriate treatment.

Patient authorizes Metro MediSpa to obtain on my behalf medical laboratories, diagnostic testing, physicians and dispensing pharmacies. In addition, Patient authorizes and instructs Metro MediSpa and physicians referred by Metro MediSpa (“Physicians”) and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the MHF, laboratory diagnostic tests, and other information submitted to Metro MediSpa under this agreement. Patient agrees to present photo identification upon any blood testing pursuant to a Prescription or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by Metro MediSpa and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or other insurance.

I further understand and agree that Metro MediSpa and Physicians are rendering the medical care, services and treatment and that Metro MediSpa is instructed and authorized to arrange for the prescribed pharmaceuticals to be dispensed and sent to me by a pharmacy in my country of residence. Patient covenants and agrees to comply with the method of instructions, treatment and dosage schedules prescribed by the Physician, to immediately cease any medical treatment prescribed by the Physician in the event of any adverse reaction or side effect arising from prescribed treatment, and to immediately provide Metro-MediSpa and Physician in the event of any adverse reaction or side effect arising from prescribed treatment, and to immediately provide Metro MediSpa and Physicians with written notice via fax to 888-831-4818 of any such adverse reaction or side effect. Patient acknowledges that diagnosis and treatment may involve risk of injury, and that Metro MediSpa and Physician have made no guarantees or warranties with respect to the above described diagnostic testing, analysis of test results, examination of medical history or hormone treatment. Patient is aware of the nature, risk, and possible alternative methods of treatment, possible consequences, and possible complications involved in such hormone replacement treatment. Patient acknowledges that human chorionic gonadotropin involves the use of a medical drug approved for one purpose, for a new and different purpose in an effort to obtain a desired objective of medical treatment. Nonetheless, patient consents to such care and treatment, and executes this Agreement with a complete, informed understanding of such hormone replacement therapy for the purpose of authorizing Physician to administer such treatment to relieve body ailments and attempt to enhance Patients physical condition and health. Patient further acknowledges that the methods of medical treatment offered by Metro MediSpa and Physician are not accompanied by any claims, guarantees, promises or warranties. It is fully agreed and understood by the patient that products purchased from Metro MediSpa require medical prescription and as such are NOT returnable or refundable under any circumstance under both Federal and/or State laws. It is unlawful for a pharmacy to accept the return of prescription medications once they have left the control of the pharmacy.

Patient is freely seeking medical consultation via the Internet or direct contact and acknowledges and consent to Physician reviewing Patient’s medical history without having the opportunity to conduct an in-person physical examination. Patient solicits METRO MEDISPA for a specific prescription medical to treat an already-identified medical or cosmetic condition. Patient agrees that Physician’s consultations, diagnoses, and treatments will be deemed to have occurred in North Carolina, where Physician is licensed to practice medicine.

Patient represents that he or she is under the care of a primary care physician and that Physician will not reply or substitute the advice of Physician should it conflict with the advice given to me by Patient’s primary care physician. Before taking any medication prescribed by Physician, Patient agrees to have a comprehensive physical examination by his or her primary care physician. Patient agrees to notify his or her primary care physician and advise such physician that the Patient is undergoing hormone replacement therapy.

Patient acknowledges that under North Carolina law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. North Carolina law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to North Carolina law.

Patient acknowledges and agrees that Metro MediSpa is not responsible for the negligent or intentional acts or omissions of any health care provider or supplier that Patient is referred or for any action or inaction taken by Patient, that the total liability of Metro MediSpa , its officers, directors, employees, agents, and stockholders is limited to the purchase price of any direct, indirect, special, incidental, consequential, or punitive damages. During Patients relationship with Metro MediSpa and Physician, Metro MediSpa and Physician will convey to Patient a range of proprietary business information, including, confidential, proprietary and uniquely valuable to Metro MediSpa and gravely affects the conduct of business of Metro MediSpa and Metro MediSpa's goodwill. Patient agrees not to disclose, divulge or communicate, in any fashion, form, or manner, either directly or indirectly, any Confidential Information or take any action that may result in disclosure of Confidential Information to any third party person, firm, or business. Based on the above-understanding, Patient agrees to release Metro MediSpa, its officers, directors, employees, agents and shareholders, and Physician from any and all liability associated with or arising from the Physician's consultation or from the medical, physical, behavioral or other effects of any medication or treatment that may be ordered, prescribed or purchased as a result of the Physician's consultation.

This Agreement shall be governed, construed and enforced in accordance with the laws of the State of Florida, applicable to agreements made and to be performed entirely within such State, without regard to principles of conflict of laws. Any disputes arising out of, in connection with or with respect to this Agreement, shall be adjusted in a court of competent jurisdiction sitting in the state of North Carolina and nowhere else. Patient hereby irrevocably submits to the jurisdiction of such court for the purposes of any suit, civil action or other proceeding arising out of, in connection with or with respect to this Agreement. In the event of any litigation arising out of this Agreement, the prevailing party shall be entitled to recover all expenses and costs incurred, including reasonable attorney's fees and legal assistants' fees.

This Agreement contains the entire understanding of the parties and supersedes and merges all prior and contemporaneous agreements and discussions between the parties. Any and all representations or agreements by any agent or representative of either party not contained in this Agreement shall be null, void, and of no effect.

If any provision of this Agreement or the application thereof to any person or circumstances is invalid or unenforceable in any jurisdiction, the remainder hereof, and all application of such provision to such person or circumstances in any other jurisdiction, shall not be effected thereby, and to this end the provisions of this Agreement shall be severable.

Patient covenants and agrees to indemnify, defend, protect , and hold harmless, and Physician and their respective officers, directors, employees, stockholders, assigns, successors, and affiliates ("Indemnified Parties") from, against and in respect of all liabilities, losses, claims, damages, punitive damages, cause of action, lawsuits, administrative proceedings, investigations, demands, judgments, settlement payments, deficiencies, penalties, fines, interest and costs and expenses suffered, sustained, incurred or paid by the Indemnified Parties in connection with, resulting from or arising out of, directly or indirectly, Metro MediSpa and/or Physician's rendering medical care services, advice and/or treatment, Patient's failure to disclose all relevant information regarding Patient's medical and physical condition, acts or omissions of Metro MediSpa or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Metro MediSpa or Physician. Patient is aware of potential side effects associated with the above-described treatment, accepts all risks involved in taking medication and will not seek indemnification or damages from the Indemnified Parties there from.

By:____ By:____

Patient's Name (Print) Date Metro Medi Spa Date

Signature:____

“Off Label” Use of HCG

______ (initial) I understand that this therapy includes “off-label” use of the FDA approved medication HCG Human Chorionic Gonadotropin. I understand that this medication is FDA approved for other medical treatment modalities and has not been approved for the purpose of weight loss. (“Off-label” use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them.) “Off-label” prescribing is a legal and common practice by physicians in the United States.

Statement from the FDA

_____ (initial) I have been notified that since 1975, the FDA has required labeling and advertising of HCG to state: “HCG has not been demonstrated to be an effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or “normal” distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets”

Treatment-Related Risk

_____ (initial) I understand that there are certain side affected associated with this medication treatment. These may include lower extremity water retention, mild dizziness, migraine headaches, irregular menses and occasional bruises at the injection site. I may also develop infection at the injection sire if I use improper technique. These side effects are reversible by dosage adjustment or stopping therapy.

I understand that the following conditions are contraindicated for the use of HCG therapy: Type 1 Diabetes, cardiac disease, CHF, prostate cancer, history or reproductive cancer, PCOS (poly-cystic ovarian syndrome) kidney disease, chronic respiratory illness, pregnancy and other serious medical conditions. I have read and understand the contraindications for HCG therapy and understand that my test results and/or past and current medical condition(s) may prohibit me from receiving the HCG medication.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician. I understand that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

I understand that if any of these side effects do occur, I will notify my physician and stop treatment immediately so that my treatment plan can be re-evaluated.

By:____

Patient’s Name (Print Date

Signature:____