REGISTRATION FORM

(Please Print)

PATIENT INFORMATION			
Patient's last name:	First:		Middle Initial:
Birth date: / /	Social Security no.:		
Street address:	Phone no.: ( )	Email address:	
P.O. box:	City:	State:	ZIP Code:
Chose clinic because/Referred to clinic by:			

MEDICAL HISTORY
Please list all medications you are currently taking:
List of allergies:
List of current medical conditions:

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Mobile phone no.: ( )
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in my health.			
Patient/Guardian signature		*Date*	

Name:_____

Date of Birth: ___/____/_____

For text reminders please list your wireless provider & mobile number
Phone Number : _____
Wireless Provider:_____

Height :_____ Weight: _____ estimated BMI : _____

Please Circle Answer

Are you over 75 years of age? Yes or No

History of heart disease? Yes or No

History of heart attack? Yes or No

Any stents in the heart? Yes or No

History of heart surgery? Yes or No

Do you have closed angle glaucoma? Yes or No

Do you Carry Passport insurance? Yes or No

Note: We **DO NOT** see passport patients, if you have passport and fail to tell us passport will take your insurance away.

Narcotic Consent Form

I _____ agree to all terms below:

1) All pain medicine/narcotics will be obtained from:
Pharmacy _____Pharm Ph # _____
Pharm Fax # (If known) _____

2) I will not seek pain medicine/narcotics from another doctor/ provider.
3) I will adhere to dosing instructions as prescribed and will not self-increase.
4) I will not give or sell my pain medicine/narcotics to **anyone**.
5) I will not receive pain medicine/narcotics from **anyone**.
6) I will be responsible and keep pain medicine/narcotics safe at all times.
7) In the event of lost, stolen, or any mishaps I will not request replacement of pain medicine/narcotics.
8) If I become dependent on pain medicine/narcotics, or possess even a small risk of addiction I will see an addiction specialist if my doctor deems necessary.
9) I will be compliant with blood/urine test for drug monitoring when asked by my provider or when randomly selected.
10) I will avoid the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol, or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens.)
11) I will exercise complete honesty with my doctor and any other health care persons involved in my pain management, such as pharmacists, emergency departments, etc. in reporting all pain medications/narcotics.
12) I understand I may be called in for a random pill count, failure to come in for count could be grounds for dismissal.
13) We will check the state pharmacy board periodically to ensure you are not obtaining controlled prescriptions from other providers or using multiple pharmacies.
14) Failure to adhere to this agreement could jeopardize my doctor/patient relationship thus stopping the prescribing of pain/narcotic medications and may even result in dismissal from the practice.

Patient name (Print please): _____

Patient signature: _____ Date: _____

Privacy Form

I, _____ DOB: _____
have been provided with a copy of the Privacy Practices for the Protected Health by Nair Internal Medicines Body Rx Louisville. I have read and understand all my rights, as explained in the detail in this notice.

Signature _____ Date

May we leave a message which may contain Private Health Information? YES or NO

on which number(s) (Circle all that apply) HOME CELL WORK

Home# (___)_____ Cell # (___)_____Work # (___)_____

I understand that if I do not give Body Rx **written permission** to release Private Health Information, they cannot release information to anyone other than myself. This includes my spouse (if married) or my parents (unless I am a minor under 18). If I choose not to list anyone below and an event arises whereby I need a report, I must pick that up myself. **At no time will a verbal authorization be accepted.**

The following individuals have my permission to obtain my private health information.

Name:	Relationship
_____	_____
_____	_____
_____	_____

FINANCIAL POLICY
All services require payment prior to actual services being done.
NO REFUNDS GIVEN; insure you have correctly answered the prescreen to avoid paying for this service that you DO NOT qualify for.

Forms of payment accepted:
cash, credit, or debit

NO CHECKS
NO HEALTH SAVINGS ACCOUNT
NO FLEXIBLE SPENDING ACCOUNT

Body Rx and Dr. Nair. enforce a 24-hour cancellation policy for **ALL** appointments. In order to reschedule your appointment, you must notify Body Rx at (502)882-8680 24 hours before your scheduled appointment time to avoid being charged a $35 cancellation/no show fee. You will be dismissed from the program if there are three no shows on your account.

With our Weight Management Program Dr. Nair does allow a 3-month grace period between appointments. **If you are not back to see him within three months from your previous visit, the program does start back over and you will be charged the initial visit fee of $135 again.** The program works best when seeing Dr. Nair as close to once a month as possible. Please try to abide by this timeline.

Client name (Printed) _____

Client Signature_____ Date_____

Patient Informed Consent for Weight Loss Program

Procedure and Alternatives:

I, _____, authorize Dr. Nair, and his team, to assist me in my weight reduction efforts. I understand my treatment may involve, but is not limited to, the use of appetite suppressants and other medications as needed for more than 12 weeks.

I understand it is my responsibility to follow the instructions carefully, and report any significant medical problems that I think may relate, to the doctor treating me as soon as possible. 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 the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that much of my success in the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

Patient Consent

I have read and fully understand this consent form. I realize that I should not sign this form if all items have not been explained, or if any questions concerning the program have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment as well as all other treatments in this program not involving the appetite suppressants. I understand that if I have Glaucoma I am unable to participate in the weight loss program due to contradictions in the medications.

Patient Signature _____ Date _____

Consent for Release of Medical Information

I hereby grant Dr. Nair and designated members of his staff, permission to contact me and leave messages pertaining to my medical care (e.g. appointment reminders, test results, prescription information etc.) with those listed below.

Contact _____ Phone Number _____

Relationship _____

Notice of Receipt of Privacy Practices

I have been presented with a copy of the privacy practices, as required by HIPAA, for the office of BodyRx Louisville. I have been given the opportunity to read and receive clarification of any

questions I may have pertaining to the privacy practices.

Signature _____ Date _____

Do you know what we have to offer at our medical spa?

Please circle anything that interests you; we would love to tell you more about it!

bodyrxlouisville.com

Body Treatments
Massage
Body Wraps
Body Polish
Back Treatments
Latisse

Skin Care Products
Glo Therapeutics
Glo Minerals
Glytone
Avene

Facial Treatments
Lash & Brow tinting
Chemical Peels
Customized facial
Laser facial

Injectables
Botox
Dermal Fillers

Vein Treatments
Laser Spider Vein Removal
Sclerotherapy

Hair Removal
Facial Waxing
Threading
Laser Hair Removal

Weight Management
Medical Weight Loss Program
Ultra Burn Lipo Injections
B12 Injections

Do you have any skin concerns?_____

_____

If you would like us to contact you regarding our services, please provide us with the following information:

Name:_____Phone #:_____

_____

Email:_____

May we include you in our monthly promotional e-mails? Y N

Welcome to Riverside Medical Professional and Body RX Louisville
8594 Dixie Highway
(502)882-8680

Specialists include:
Dr. Suresh Nair- Medical Weight Loss
Dr. Sarita Nair- Botox & fillers
Monica Caporale- Massage Therapist
Holly Hoskins-Aesthetician
Kim Cashion APRN- Botox / Fillers
Stacey Koch APRN-Medical Weight loss & Botox/fillers

Dixie Office Hours:
Tuesday – Thursday: 11am to 7pm
Fridays: 9am to 5pm
Saturday: 10am-4pm
*Closed on Holidays

Hurstbourne Office Hours:
Monday – Friday 10am to 6pm
Saturday 9am to 1pm
Closed on Holidays

Telephone and Communications:
Our staff at the Dixie location answers phone calls Tuesdays- Thursdays, 11am-7pm, Fridays 9am-5pm & on Saturday from 10am-4pm. After hours, our phone is directed to an answering service.
Our staff at the Hurstbourne office answers phone calls Monday-Friday 10am -6pm & on Saturday 9am-1pm

Appointments:
All patients are seen by appointments only. Appointment reminder text and email are done 24-48 hours in advance. It is the **patient's responsibility** to keep the scheduled appointment. We understand that there are occasional circumstances that might keep you from the appointment. When this happens, we request 24 hours in advance notice. Without the 24-hour notice, a $35 no show fee will be charged.

Refills:
Refills- **No refills will be given unless seen by a doctor**.

We do follow HIPAA (Health Insurance Portability & Accountability Act)
For more information, please refer to “HIPAA Notice of Privacy Practices” literature also included in the new patient packet.

Effective 3/1/2010

HIPAA Notice of Privacy Practices

BodyRx Louisville
8594 Dixie Highway
Louisville, KY 40258
502.882.8680
BodyRx Louisville
601 south Hurstbourne Pkway
Louisville, KY 40222

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

This medical practice collects health information about you and stores it in a chart and in an electronic personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or

disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.