Capital Area Physician Weight & Wellness Center

124 Park Street Southeast, Suite 203, Vienna, VA 22180
44121 Harry Byrd Highway, Suite 250, Ashburn, VA 20147
Ph: 703.255.6010 Fax: 703.255.6011
www.capwwc.com

Capital Area Internal Medicine - dba Capital Area Physician Weight & Wellness Center (CAPWWC) Notice of Privacy Practice

This notice describes the way in which medical and personal information pertaining to you may be used and disclosed. It also, explains how you can access your health information. Please review it carefully and sign the attached acknowledgement receipt at the bottom of this notice and return it to the receptionist.

At CAPWWC, the staff is committed to the protection of your private health information. Within our office access to your information is limited to those employees who need access in order to perform their jobs.

CAPWWC may use and disclose protected health information in order to facilitate treatment, collect payments and for internal healthcare operations. Examples of these include but are not limited to referral to other healthcare providers, life insurance physicals, and home healthcare agencies. Payment examples include your health insurance provider for claims and coordination of benefits, workman's compensation, or similar programs: Collection's agencies, etc. Healthcare operations include auditing of records and internal quality control.

CAPWWC is required by law to use and/or disclose protected health information without the patients' written consent or authorization in certain circumstances. These include reporting a crime, responding to a subpoena, warrant or court order; public health officials concerned with controlling disease, disability, and injury.

CAPWWC may use or disclose protected health information to your personal representative whom you e authorized to act on your behalf in making decisions related to your health care.

CAPWWC Weight Loss Clinic will contact patients at phone numbers provided to us by the patient in order to give appointment reminders or other information regarding treatment and/or tests results.

CAPWWC Weight Loss Clinic will not use or disclose a patient's protected health information as is described in this notice without the individual's written authorization. This authorization may be revoked at any time in writing. Exceptions are those described above as required by law.

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CAPWWC Weight Loss Clinic will abide by this notice, which is currently in effect as of April 14, 2003, at the time of disclosure. We reserve the right to revise the terms of this notice and make new provisions effective for all protected health information we maintain.

CAPWWC Weight Loss Clinic will keep a posted copy of our current privacy practices in our lobby area. Copies of this notice may also be obtained at any time in our office.

Any person/patient, who believes their privacy rights have been violated, may register a complaint with our office manager at 703-255-6010, and to the Secretary of Health of Human Services.

It is our office policy that no retaliatory action will be made against any individual who submits a complaint of non-compliance of the privacy standards.

You have the legal right to inspect copies of your protected health information. This requires a written, signed, and dated request. (as allowed by State law, reasonable copy fees may apply)

If you believe your health information is inaccurate or incomplete, you may request to amend your information. In the event that we deny your request, we will inform you of our reasons for such a denial in writing.

You have the legal right to request restrictions on certain uses of your protected health information as provided by 45CFR 154.522(a). By law we are not required to comply with a requested restriction.

Acknowledgement of Privacy Practices:

I have received a notice of privacy practices, outlining my rights regarding my protected health information and the specific ways in which my private health information may be used and disclosed as allowed under state and federal law.

Patient or legal Representative: _____Date_____

Relationship of above if not signed by patient_____

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WEIGHT LOSS CONSENT FORM

I _____authorize Dr. Sree L. Gogineni and her staff at CAPWWC to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low-calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices 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 remaining overweight or obese. Risks of this program may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, 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.

I understand that much of the success of 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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form. *If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.*

Date_____Time_____

Witness_____Patient_____Weight-Loss

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Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 1/2 pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have the right to ask questions about the potential health risks of the program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program.

I have read the above:

Patient's Signature: _____Date_____

Release of Medical Records

I give permission for my medical records (blood work, chart, EKG) to be released to:

_____

_____

_____

Patient's
Name_____Signature_____Date_____

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BEFORE" AND "AFTER" PHOTOS

I_____, give my permission for NOVA ABC to take my "before" and "after" photographs. (*Photographs will not be used for advertising without patient permission)*

Signature_____

Date: _____

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

1. I_____ (patient or patient's guardian) authorize Dr. Sree L. Gogineni to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on the shorter-term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric physician, I have found the appetite suppressants helpful for periods far more than 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer-term studies, and recommendations of university-based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible,

as with most other medications, that there could be serious side effects (as noted below)."

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of the side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. 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.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. A balanced calorie counting program or and exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees, and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

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IV. No Guarantees:

I understand that much of the success of 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 my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them 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 and regarding other treatments not involving the appetite suppressants.

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 YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE_____TIME_____

PATIENT_____WITNESS_____

(Can be signed by legal guardian if patient is a minor)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's Signature_____

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CAPWWC Hours of Operation and Cancellation Policy

We make every effort to make sure your visits are pleasant and efficient for you. Please make every effort to arrive at your appointment on time. If you are unable to make your scheduled time, just call and notify our office. (AFTER HOURS YOU CAN LEAVE A MESSAGE ON OUR PHONE) Or email us at viennacaim@gmail.com Our patient hours are as follow:

Monday 8 AM to 4:30 PM

Tuesday 8 AM to 4:30 PM

Wednesday 8 AM to 4:30 PM

Thursday 8 AM to 4:30 PM

Friday 8 AM to 4:30 PM

If you need to miss an appointment, please call 24 hours in advance to cancel in order to avoid a $50.00 no-show fee. Again, you can call after hours and leave a message on our answering machine. Our phone number is 703-494-1020 and press #8 to leave a message.

I ACKNOWLEDGE THE ABOVE-MENTIONED NO-SHOW POLICY AND UNDERSTAND I WILL BE CHARGED $50.00 FOR FAILURE TO GIVE 24 HOURS NOTICE TO THE OFFICE OF CANCELLATION.

_____ _____

Signature DATE

_____

Name