SCALEDownMD℠
Educate. Achieve. Sustain. Medical Weight Loss

Better Living MD℠
Conventional Medicine, Holistic Approach

PATIENT TREATMENT INFORMATION

Please print clearly – all information is confidential

Legal Name _____ **Nick Name (prefer to be called):** _____

Phone (circle preferred) (*H*) _____ (W) _____ (C) _____

Address _____ **Apt#** _____ **EMAIL** _____

City _____ **State** _____ **Zip** _____

Occupation and Employer _____ **Age** _____ **Date of Birth** _____

How did you hear about us _____

Emergency Contact _____ **Relationship** _____ **Emergency Contact Phone #** _____

Have you ever had an adverse reaction to any medication(s) or foods or do you have any known allergies? Please list them:

_____

Symptoms to be addressed: _____

_____

How long have you had these symptoms? _____

What have you done/ are doing now to treat your symptoms? _____

_____

Do you exercise? ☐ yes ☐ no **What type of exercise do you do?** _____

Height: _____ **inches** **Current Weight:** _____ **lbs**

Do you smoke? ☐ yes ☐ no Do you do any recreational drugs or alcohol? ☐ yes ☐ no _____

(If Applicable) Are you Pregnant? ☐ yes ☐ no **Do you have a regular menstrual cycle ?** ☐ yes ☐ no
Are you post-menopausal ? □ yes □ no

Do you take any medications and/ or supplements: ☐ yes ☐ no. If yes please list them on the following page.

Please list your history of medical problems: _____

_____

Please list all of your prior operations: _____

_____

Please list your family medical history specifically any cancers, heart conditions, diabetes, or thyroid conditions:

_____

IN ORDER TO PROPERLY TREAT YOU, WE MUST BE AWARE OF ALL YOUR EXISTING AND PREVIOUS PHYSICAL OR/AND HEALTH RELATED CONDITIONS. BY SIGNING BELOW, I AM REPRESENTING THAT I HAVE CAREFULLY REVIEWED THIS DISCLOSURE FORM AND I HAVE FULLY DISCLOSED ALL MY KNOWN HEALTH RELATED CONDITIONS. FURTHER, I HEREBY REPRESENT THAT I WILL KEEP SATISH CUDDAPAH, MD, FULLY UPDATED REGARDING MY PHYSICAL HEALTH

I CERTIFY THAT I HAVE READ OR HAVE HAD THIS FORM READ TO ME AND THAT I UNDERSTAND ITS CONTENTS.

SIGNATURE OF PATIENT _____ **DATE** _____

NAME (PRINT) _____

IF PATIENT IS A MINOR PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

NAME (PRINT) _____ **RELATIONSHIP** _____

List of Medications and or Supplements

1.
2.
3.
4.
5.
6.
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18.
19.
20.

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CONSENT TO EVALUATION AND TREATMENT

I, the undersigned, having been fully informed by Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD of the hazards and possible consequences involved in any treatment I receive. I nevertheless consent to and request such treatment and agree to hold Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD free and harmless for any claims, demands, or suits for damages from any injury or complications whatever, save negligence, that may result from such treatment.

I, the undersigned, understand that Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD offers several specialized services as clinically necessary. It has been made clear to me that any treatment I receive must beforehand be accompanied by a physical examination and diagnosis by the physician. I understand that I must have a primary care physician for standard medical and preventative care. I agree to immediately report to my physician any adverse reaction or problem that might be related advice or services offered to me by Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD. Furthermore, to minimize an adverse reaction and optimize clinical outcome, I agree to maintain compliance with the prescribed treatment (s) and follow up physician appointments as well as immediately notify our office of any new changes in treatments provided by other health care providers.

I, the undersigned, understand that some of the treatments recommended by Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD do not fall under the general definition of conventional medicine. I understand that conventional medicine is generally defined as those methods of diagnosis, treatment, or intervention offered by most licensed physicians as part of generally-accepted methods of routine practice.

I, the undersigned, further understand that Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD may perform a variety of laboratory tests as well as recommend a number of innovative, non-conventional, non-standard, alternative, natural and pharmaceutical treatments that may not fall under the general definition of conventional medicine and may not be subject to FDA regulation. I also understand that many physicians consider these treatments to be Holistic and often disagree not only with the lab test interpretation but also with the use of these natural therapies. I understand that it is not always possible to give a definitive diagnosis and any diagnosis may not be agreed upon by other physicians and may lie outside of standard conventional criteria and diagnostic criteria.

I, the undersigned, voluntarily request that Satish Cuddapah, M.D., and such associates, technical assistants and other health care providers as he may deem necessary, evaluate and treat my condition.

I, the undersigned, acknowledge that I have not been promised or guaranteed any specific benefit from the services offered at Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD.

I CERTIFY THAT I HAVE READ OR HAVE HAD THIS CONSENT TO EVALUATION AND TREATMENT READ TO ME AND THAT I UNDERSTAND ITS CONTENTS.

SIGNATURE OF PATIENT _____ **DATE** _____

NAME (PRINT) _____

IF PATIENT IS A MINOR PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

NAME (PRINT) _____ **RELATIONSHIP** _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Satish Cuddapah, MD, P.C. D/B/A ScaleDown MD and BetterLiving MD to release complete medical information contained in my patient records to my physician or other healthcare service providers and to my insurance company. The release of information shall include, but is not limited to, all records, reports, X-rays and photostatic copies, relating to any examination, treatment or opinion concerning any medical or health related condition I have had in the past, now have, or may have in the future. I also authorize Satish Cuddapah, MD, P.C. to receive any necessary health related information from my physician or other healthcare service providers.

I UNDERSTAND THAT MY MEDICAL INFORMATION IS CONFIDENTIAL AND PROTECTED BY A PHYSICIAN-PATIENT PRIVILEGE, AND THAT I AM WAIVING THE PHYSICIAN-PATIENT PRIVILEGE.

_____ Initial here if I do not wish to discuss or disclose my private medical information with anyone unless as authorized per HIPAA law

_____ Initial here- I authorize the following individual (s) full access to my private health care records and allow the staff of BetterLiving MD to discuss my private health care with the following individual(s)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ Date: _____
Patient Signature

_____
Print Name

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Please sign below to fully acknowledge understanding and agreement of the above disclosure.

_____ _____

Signature Date

_____

Print Name