

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, ST, ZIP**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Daytime Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notify in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male\Female

Are there other smokers in your household? Y\N

How long have you been using nicotine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much nicotine do you use per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of work do you do?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you ever been diagnosed with?***

COPD Y\N ADD/ADHD Y\N Shortness of Breath Y\N

Prostatic Hypertrophy Y\N Cardiac Arrhythmia Y\N Acute Angle Glaucoma Y\N

Emphysema Y\N Chronic Bronchitis Y\N Bladder Dysfunction Y\N

High Blood Pressure Y\N Are you pregnant? Y\N Asthma Y\N

HIV\AIDS Y\N Bio\Polar Disorder? Y\N

 *(If Yes, What medication has been prescribed for this?)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you been addicted to any of the following substances?***

Alcohol Y\N Cocaine Y\N Barbiturates Y\N

Amphetamines Y\N Heroin Y\N Methadone Y\N

Marijuana Y\N Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you experienced any of the following?***

Head or Brain Injuries Y\N When? \_\_\_\_\_\_\_\_\_\_\_\_\_ Seizures Y\N When? \_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac Bypass Surgery Y\N When? \_\_\_\_\_\_\_\_\_\_\_\_\_ Extreme Anxiety Y\N When? \_\_\_\_\_\_\_\_\_\_\_\_\_

***Do you suffer from or take medication for depression? Y\N What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Are you normally sensitive or resistant to most drugs?*** ***\_\_\_ Normal \_\_\_Sensitive \_\_\_ Resistant***

Medications Now Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Past 10 Years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***How did you hear of us?***

Radio\_\_\_\_ Which station?\_\_\_\_\_\_\_\_\_\_ Internet\_\_\_\_\_ Friend\_\_\_\_\_ Dr. referral\_\_\_\_\_

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 **DISCLOSURE AND CONSENT**

**TO THE PATIENT**: You have the right as a patient to be informed about your condition and the recommended medical or diagnostic procedure to be used so you may make the decision whether to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request the Welplex Stop Smoking Clinic and their Licensed Physician(s) and such associates, technical assistants and other health care providers they may deem necessary to treat my condition which has been explained to me as: NICOTINE DEPENDENCY REFRACTORY TO CESSATION BY OTHER MEANS. I (we) understand the following medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures. I (we) understand this procedure utilizes ANTI-CHOLINERGIC MEDICATIONS, ATROPINE and LEVSIN, POTENTIATED BY PHENERGAN OR SIMILAR MEDICATION WITH A CARRIER OF LIDOCAINE. These medications have been F.D.A. approved for a variety of applications other than smoking cessation and in themselves are not addictive. I (we) understand the physician may discover other or different conditions, which require additional or different procedures than those planned. I (we) authorize the physician and such associates, technical assistants, and other health care providers to perform other such procedures deemed necessary in their professional judgment. I (we) understand no warranty or guarantee has been made to me as to result or cure. There may be risks and hazards related to the performance of medical and/or diagnostic procedures; the potential for infection, blood clots, hemorrhage, idiosyncratic or allergic reaction. I (we) also realize the following risks and hazards are associated with this particular procedure including DRY MOUTH OR TIGHTNESS OF THE THROAT DUE TO REDUCED SALIVATION, INCREASED HEART RATE, POSSIBLE URINARY RETENTION, BLURRED VISION, LIGHT-HEADEDNESS, RESTLESSNESS MUSCLE SPASMS AND IN SOME RARE CASES POSSIBLE HALLUCINATIONS, SHORT TERM MEMORY LOSS OR BIZARRE BEHAVIOR. The aforementioned symptoms are possible for ten to twelve hours following the procedure.

I (we) SHOULD NOT PARTICIPATE in the treatment if suffering from acute angle glaucoma, enlarged prostate, cardio arrhythmia, or if pregnant.

I (we) have been given an opportunity to ask questions about my (our) condition, alternative forms of treatment, the risks of non-treatment, the procedure to be used and the risks and hazards involved. I (we) believe sufficient information has been given in order to give my (our) consent to treatment. I (we) certify this form has been fully explained to me. I (we) have read it or had it read to me and understand its contents.

**DISCLOSURE AND CONSENT**

**PAGE TWO**

The undersigned consents to any x-rays or laboratory examinations and medical treatment rendered the patient by the attending physician and by designated clinic personnel. The assistants I (we) understand are not licensed physicians and may not treat or diagnose any illness, injury, or medical condition except under the supervision of a licensed physician. These assistants may include: Registered Nurses, Licensed Vocational Nurses, Nurses Aids, Technicians, Radiology Technicians, Dieticians, Health Educators, Certified Medical Assistants and other persons who are not licensed physicians, but who are deemed by the physician to be trained to assist under the general and special instructions provided to them. I (we) further understand that I (we) may revoke this authorization at any time prior to any procedure.

With regard to the smoking cessation procedure, the patient understands and agrees that he/she WILL NOT OPERATE AN AUTOMOBILE FOR 5-6 HOURS following the treatment. **\_\_\_\_\_\_(initial)**

I understand that if I have followed all instructions and cooperated fully and completely concerning the smoking cessation treatment, should I return to smoking within a 6 months period I may return for one additional treatment. The clinic will provide all necessary medical testing free of charge. The patient will be responsible for a $149.00 office visit charge, plus the cost of medications. Subsequent re-treatments (within one year of the initial treatment) will be provided at a cost of $315.00 plus the cost of medications. Re-treatment beyond one year will provided at $50.00 discount of current fees and will include medications and an EKG.

**Follow Up Medications:** I acknowledge receipt of prescribing information on medicines that have been provided to me by the clinic. I should receive prescribing information from my pharmacist for prescriptions I have filled.

**PRIVATE INSURANCE AND MEDICARE\MEDICAID COVERAGE.**

All Physicians and or practitioners are excluded from all MEDICARE\MEDICAID\ PRIVATE INSURANCE COVERAGE PLANS. (In compliance with **MCM Section 3044.8**)

\_\_\_\_\_ Initial Beneficiary\Patient or his or her legal representative agrees **not to submit a claim to Medicare\Medicaid** or to ask the physician or practitioner to submit a claim to Medicare\Medicaid.

\_\_\_\_\_ Initial Beneficiary\Patient or his or her legal representative understands that Medicare payment **will not** be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare.

**DISCLOSURE AND CONCENT**

#### PAGE THREE

**INSURANCE AND MEDICARE COVERAGE. (Cont)**

All Physicians and or practitioners are excluded from all MEDICARE\MEDICADE\PRIVATE INSURANCE COVERAGE PLANS. (i.e. “OPT OUT”) (In compliance with **MCM Section 3044.8**) (Cont)

\_\_\_\_\_ Initial Beneficiary\Patient or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

\_\_\_\_\_ Initial Beneficiary\Patient or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

\_\_\_\_\_ Initial I understand the Welplex Stop Smoking Clinic DOES NOT ACCEPT MEDICARE ASSIGNMENTS.

By my (our) signatures, I (we) consent to this agreement and each acknowledges receipt of a true copy thereof.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Patient |  | Date |  | Witness |
|  |  |  |  |  |
| Printed Name |  |  |  |  |

NETIHER THE ATTENDING PHYSICIAN OR THE FACILITY WILL ACCEPT ANY RESPONSIBILITY FOR THE WELFARE OF ANY PATIENT LEAVING THE PREMISES NOT ACCOMPANIED BY AN ADULT!!! PATIENT UNDERSTANDS THAT HE/SHE DOES SO AT THEIR OWN RISK AND AGAINST PROFESSIONAL PRESCRIPTION AND INSTRUCTIONS.



*PATIENT RESPONSIBILITIES*

***I*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***am aware of the following requirements in order to participate in the Welplex Stop Program.***

* I understand this is **NOT a Miracle Treatment**.
* I **must want to quit** smoking, chewing, dipping or any other Nicotine dependency.
* I understand that this procedure takes a **minimum of two (2) hours** and I will have a driver take me home.
* I must follow all **instructions given.**
* **Finish all medication** given unless otherwise directed by the Physician.
* I agree that I will have to change my **behavior, and habits as directed by the clinic**.
* If I have **any questions or need assistance after my treatment**, I will call the Welplex office **during regular business hours**  (727-539-8900).
* **Urgent Line:** Call 727-539-8900, **Press Existing Patient**, and leave a message. Include name, phone number, any problems you are experiencing and date you were treated.
	+ - A medical professional will **return calls Monday – Friday during normal business hours (9:00am – 5:00pm)**.
		- **Weekend messages** will be pickup by our **nurse on callbetween 9:00am and 12:00pm and your call will be returned**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES, HIPPA CONSENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this company’s Notice of Privacy Practices.

I hereby give my consent for Welplex Stop Smoking Clinics to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

With this consent, Welplex Stop Smoking Clinics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointed reminders and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Welplex Stop Smoking Clinics may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Welplex Stop Smoking Clinics may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Welplex restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Welplex Stop Smoking Clinics use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Welplex Stop Smoking Clinics may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian Date