1901 Lafayette Road, Ste 100
Crawfordsville, IN 47933
(765) 362-SLIM

8803 N Meridian St, St 100
Indianapolis, IN 46260
(317) 840-8188

INITIAL APPOINTMENT INSTRUCTIONS AND PROCEDURES

Please Review Carefully Prior to Your First Visit

Welcome to our practice. We are excited you have decided to join our program. Our staff is committed to helping you reach your weight loss and fitness goals. Along with your hard work and determination, we hope to motivate you to success. Below you will find instructions for your initial consultation.

APPOINTMENT TIME: _____

24-Hour Notification Required to Reschedule Your Appointment or You Will Forfeit Your $50 Deposit

1. Your enrollment materials must be filled out completely before you come to your appointment.

2. Be sure to be fasting 6 hrs. prior to your appointment. You will need to be prepared to get you blood drawn at our in-office site.

3. When you come to your appointment, please first check-in at the window. You will be asked for your black binder and to pay your $245. We accept cash, check, debit and charge cards.

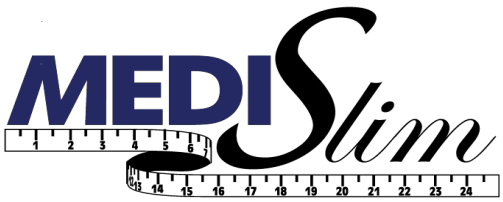
4. We will take your picture, height, weight, blood pressure, EKG, measurements, body composition, as well as a physical exam.

5. You will meet with a staff member who will discuss your weight loss and health history, do a brief physical exam, and review your body composition results.

6. At your first return visit, a staff member will outline recommendations for your own weight loss program based on the result of your blood tests, health history, and body composition results at which time medication will be dispensed.

7. You will follow-up on a weekly basis to check weight, blood pressure, and symptoms and to make any changes in your program. Please see separate information about guidelines for weekly visits.

8. Please let us know how we can make your experience a positive one!



Patient Information Form

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____Driver's License #: _____

Birthdate: _____Age: _____Sex: M F

Social Security: _____E-mail: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Arun Jain, MD FACOG / Amy Sites, MSN, FNP-C for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept cash, personal checks, and credit cards.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Medical History Form

Name: _____ Age:_____ Sex: M F

Family Physician: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes No

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Any allergies to any medications? Yes No
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____
    Menstrual: Are they regular: Yes No
    Last menstrual period: _____
    Contraception: _____
    Hormone Replacement Therapy: Yes No
    What: _____
    Birth Control Pills: Yes No
    Type: _____
    Last Check Up: _____

13. Serious Injuries: Yes No
    Specify: _____ Date: _____

14. Any Surgery: Yes No
Specify: _____ Date: _____
Specify: _____ Date: _____

15. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____
Asthma: Yes No Who: _____
Epilepsy: Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____ Jaundice	_____ Kidney Disease	_____ Liver Disease
_____ Lung Disease	_____ Rheumatic Fever	_____ Bleeding Disorder
_____Stomach Ulcers	_____ Gout	_____Nervous Breakdown
_____ Thyroid Disease	_____ Anemia	_____ Heart Valve Disorder
_____Heart Disease	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Anorexia or Bulimia	_____ Alcohol Abuse
_____ Cancer	_____ Blood Transfusion	_____ Arthritis
_____ Osteoporosis	_____ Other: _____	

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you realistically like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____
   _____
6. What has been your maximum lifetime weight (non-pregnant) and when?_____
7. Previous diets you have followed: Give dates and results of your weight loss:

   _____ _____

   _____ _____
8. Is your spouse, fiancé or partner overweight? Yes No
9. By how much is he or she overweight? _____
10. How often do you eat out? _____

11. What restaurants do you frequent?_____

12. How often do you eat "fast foods?"_____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Weekly? _____

23. Do you awaken hungry during the night? Yes No

What do you do? _____

24. What are your worst food habits? _____

25. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

26. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

27. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

28. Smoking Habits:

____ You have never smoked cigarettes, cigars or a pipe.
____ You quit smoking ____ years ago and have not smoked since.

How much do you smoke now?
____ You smoke 20 cigarettes per day (1 pack).
____ You smoke 30 cigarettes per day (1-1/2 packs).
____ You smoke 40 cigarettes per day (2 packs).

29. Typical Breakfast _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

Typical Lunch _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

Typical Dinner _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

30. Describe your usual energy level: _____

31. Activity Level: **(answer only one)**
____ Inactive—no regular physical activity with a sit-down job.
____ Light activity—no organized physical activity during leisure time.
____ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
____ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
____ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

32. Please mark the activities that you enjoy participating in.
____Walking
____Jogging
____Running
____Biking Outdoors
____Biking Indoors
____Weight Lifting
____Group Fitness Classes
____Fitness Videos at Home

33. Is there any activities that you would enjoy participating in but feel like you are physically unable to?

_____

34. Behavior style: **(answer only one)**
____ You are usually calm and easygoing.
____ You are seldom calm and persistently on the go.
____ You are hard-driving and can never relax.

35. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

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EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG / AMY SITES, MSN, FNP-C

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Dr. Arun Jain and/or Amy Sites 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 shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric weight loss physician, I have found the appetite suppressants helpful for periods far in excess of 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 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. In particular, a balanced calorie counting program or an 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 heart beat 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.

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 of 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.

WARNING

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 DR JAIN AT YOUR APPOINTMENT.

DATE: _____ TIME: _____

PATIENT: _____

(or person with authority to consent for patient)

VI. <u>PHYSICIAN DECLARATION</u>:

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.

_____

Provider's Signature

EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG / AMY SITES, MSN, FNP-C

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Weight Loss Program Consent Form

I _____ authorize Dr. Arun Jain, Amy Sites and whomever they designates as his assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit 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, lifelong 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 Dr. Jain or Amy Sites at your appointment.

Date: _____ **Time:** _____

Patient: _____
(Or person with authority to consent for patient)

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EXPERT WEIGHT MANAGEMENT

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12 Reasons

"Why I Want to Reach My Goal Weight"

Name: _____ **Date:** _____

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. We suggest that you transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: "I will read the entire card whenever I am confronted with a difficult food situation." Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

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EXPERT WEIGHT MANAGEMENT

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GUIDELINES FOR WEEKLY VISITS

This list is to help ensure that the weekly visits run smoothly for everyone. Please follow these conditions so we may serve you better. Thank you.

1. Please be sure to bring your binder and medicine bottles with you to every appointment. Both of these items are needed in order to be seen.

2. All patients are required to see the Dr. Jain or Amy Sites once every 4 weeks for medication prescribing compliance.

3. After you become established as a patient, if you are unable to come weekly you can purchase additional weeks of medication, up to 4 weeks at one time. Please let the staff know how many weeks you'd like to purchase when checking in.

4. After you have reached your goal weight, you may start the maintenance program and only come once a month for $40 a month. This is not a requirement but highly recommended in order to maintain your weight. If in the event you find yourself struggling on maintenance, the option is available to get started back on the appetite suppressants again with Dr. Jain's or Amy Sites' approval.

5. If at any time you have decided to take a break from the program, you can restart at anytime unless it has been over a year since you were last in the office. At this visit, please bring your binder, all medication bottles and weekly fee. The only exception to this rule is if you were pregnant in that time, then you may have 2 years.
***You are considered an active MediSlim patient as long as the date of your last visit does not exceed ONE (1) YEAR.**

Hours of Operation

Crawfordsville Office

1901 Lafayette Rd, Ste 100
Crawfordsville, IN 47933
(765) 362-7546

Wednesdays 8:30am – 6:00pm
Closed for lunch 1:00pm - 2:00pm

Indianapolis Office

8803 N Meridian St, Ste 100
Indianapolis, IN 46260
(317) 840-8188

Fridays 8:30am – 6:00 pm
Closed for lunch 1:00pm – 2:00pm

***Please check email, website or social media to stay informed of periodic closings or changes**

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EXPERT WEIGHT MANAGEMENT

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SUPPLEMENT MENU

These products are offered to everyone on the program. They are not required for your diet, but are just supplements for those who need it.

Each of these supplements offer 2 protein exchanges each or 4 protein and 1 milk exchange for 2 in a day

Protein Bars
($1.50 ea. or 7 for $10.00)
Cinnamon
Lemon Meringue
Lemon Zest
Fluffy Nutter
Fluffy Vanilla Crisp
Marshmallow Brownie Crisp
Nutty Caramel Crunch
Peanut Butter Mousse
Peanut Butter Cup
Salted Toffee Pretzel
Strawberry Shortcake
Sweet & Salty Peanut

Soy Snack
($1.50 ea. or 7 for $10.00)
Carmel Soy Snacks

Shakes
($2.00 each)
Chocolate Salted Caramel
Chocolate
Vanilla

Chips
($1.50 ea. or 7 for $10.00)
Honey Mustard Bites
Cheddar Bites
Pizza Bites
BBQ
Nacho

Wafers
($1.50 ea. or 5 for $10.00)
Vanilla
Mocha
Chocolate
Lemon
Raspberry

Keto Bar
($1.50 ea. or 7 for $10.00)
Peanut Butter
Chocolate
Salted Caramel
Birthday Cake

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EXPERT WEIGHT MANAGEMENT

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Emergency Care

In the event of an emergency or severe symptom while on our weight loss program you must proceed to the nearest emergency room for evaluation and treatment. These symptoms include chest pain, severe lightheadedness or dizziness, fainting, difficulty breathing, or severe abdominal pain. You should take any medications you are on with you. The ER physician may call Dr. Jain for further information.

If you have minor symptoms or questions you may call the MediSlim phone number (765-362-7546) and your call will be returned within 24 hours. We ask that you please reserve questions or concerns that are not urgent for the weekly follow-up visits.