INSPIRE WEIGHT LOSS

Patient Information

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____

Email Address: _____Primary Phone #: _____

Sex: ☐FEMALE ☐MALE

Approximate Height: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Home: (_____) _____ Cell: (_____) _____

Are you currently pregnant, breast feeding, have active cancer, or cholecystitis (active gall bladder attacks)
☐ YES ☐ NO ***If yes, you are not eligible for this program.***

Are you currently scheduled for any surgeries or procedures or traveling out of town in the next 10 weeks?
☐ YES ☐ NO

Do you have any open wounds? ☐YES ☐NO

When is your next menstrual period? _____

PATIENT QUESTIONNAIRE:

What is your current weight? _____

What is your goal weight? _____

Are you happy with your weight? ☐ YES ☐ NO

Are you interested in:

Weight Loss? ☐YES ☐ NO

Inch Reduction? ☐YES☐ NO

Skin Tightening? ☐YES☐NO

How did you hear about us? (Please circle one)
Dr. Oz Show, Facebook, Google, Instagram, Drive-by, Radio, News Ad, TV, Print Ad,
Referred by_____ Other_____

Do you experience any of the following conditions even if they are minor and go away on their own?

☐High blood pressure	☐Diabetes	☐Headaches	☐Arthritis	☐Allergies
☐Digestive Problems	☐Neck Pain	☐Hypoglycemia	☐Stress	☐Cancer
☐Heart disease	☐Numbness	☐Fibromyalgia	☐Upper Back Pain	
☐Chronic Fatigue	☐Hip/Knee Pain	☐Osteoporosis	☐Thyroid Problems	

Patient Information

FAMILY HISTORY:

If any blood relative has ever had any of the following, please check the box and indicate your relationship.

☐ Cancer	Relation: _____
☐ Diabetes	Relation: _____
☐ Heart Attack	Relation: _____
☐ Heart Disease	Relation: _____
☐ High Blood Pressure	Relation: _____
☐ Kidney Disease	Relation: _____
☐ Liver Disease	Relation: _____
☐ Migraine Headaches	Relation: _____
☐ Stroke	Relation: _____
☐ Tuberculosis	Relation: _____

HABITS

Smoking: ☐ YES ☐ NO If yes, packs daily: _____

Caffeine: ☐ YES ☐ NO Coffee/cups Daily: _____ Other Caffeine: _____

Snoring: ☐ YES ☐ NO Daytime Drowsiness? ☐ YES ☐ NO

Routinely Exercise? ☐ YES ☐ NO

What type of exercise? _____

OPERATIONS and/or HOSPITALIZATIONS:

SURGERY	DATE	REASON

MEDICATIONS: (IF YOU HAVE MORE THAN 5 MEDICATIONS, PLEASE PROVIDE A LIST.)

Please list all medications and/or supplements you are currently taking, the dosage and the reason:

DRUG/SUPPLEMENT NAME	DOSAGE	REASON

Inspire Weight Loss Office Policies

Inspire Weight Loss Lake Nona thanks you for placing trust in us for your weight loss journey. We understand that losing weight is a very personal decision; therefore, your privacy is of the utmost importance to us. We will not disclose or sell your personal and/or medical information without your written consent. We strictly adhere to all HIPAA laws protecting your privacy.

Inspire Weight Loss programs are designed to be completed under the supervision of a Doctor, Dr. Martiery Nalda or a Certified Health Coach employed by Inspire Weight Loss. Attempting a program without this supervision is at the sole risk of the patient and may result in serious health related issues. Patients are required to communicate with their primary care physician regarding any medication changes as the need for medication often decreases as the patient's weight loss increases.

Although we understand that situations may arise that prevent our patients from keeping their appointments, we have many clients eagerly waiting to get into our practice. If you should need to cancel or reschedule your appointment, please kindly provide a 24 hour notice to allow us the opportunity to offer that appointment to another client. Any missed appointments or those cancelled without sufficient notice may result in a $49.00 cancellation/broken appointment fee. Any outstanding balances owed to the practice must be paid prior to scheduling your next visit. Please also note that our appointments require a set amount of time. If you are 10 minutes late, or more, your appointment will need to be rescheduled.

In order to ensure the safety of our staff and other patients, children will not be permitted in the treatment rooms. Children must be twelve (12) years of age or older to supervise themselves in the reception area during any and all appointments. Please make any necessary arrangements for younger children prior to arriving as we are unable to provide child care in our practice.

Our practice offers financing through Care Credit for treatment costs that exceed $500.00 or more. If you are interested in financing your treatment, please ask for additional information.

Because we only provide services with proven results, your commitment is a necessity and is required to reap the benefits of the program in its entirety. Your participation and cooperation determine your individual success. It is at the discretion of the Doctor/Certified Health Coach to remove a patient from the program for non-compliance. Programs are tailored to the needs and desires of each patient; therefore, so are the costs associated with each patient's program. Due to the nature of our business and the time invested individually, ***no refunds will be issued*** for any of our services, under any circumstances. If for any reason, you are not satisfied with our service, please bring it to the attention of the Doctor/Certified Health Coach and we will do our best to come to a fair resolution.

I understand the above policies pertaining to Inspire Weight Loss Lake Nona/Dr. Martiery Nalda and staff and agree by signing below.

Printed Name: _____ Signature: _____Date:_____

OUR PRIVACY POLICY:

We value your privacy and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Furthermore, we do not sell, rent or allow the unauthorized use of names, addresses, phone numbers, email or personal information without your consent. Copies of this form, along with signatures, will be considered the original form and validated as such, should this document at any point be digitally scanned.

Medical Information Authorization Form/HIPAA

I authorize Dr. Martiery Nalda and/or her personnel to release all medical information to my family members and friends listed below. I may revoke this authorization by phone or in writing at any time.

Name Relationship to Patient Phone Number

_____

Permission to leave a message on an answering machine or voicemail: YES ____ NO ____

Patient Signature: _____Date: _____

PHOTO/VIDEO RELEASE FORM:

For good and valuable consideration, I hereby consent to the photographing of myself and/or the recording of my voice and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings to be utilized for advertising whether publicly, commercially or any other business purposes.

I further consent to the reproduction and/or authorization by Dr. Martiery Nalda, Inspire Weight Loss Lake Nona and Inspire Weight Loss Franchises to reproduce and use the said photographs and recordings of my voice for all domestic and foreign markets. Further, I understand that others, with or without the consent for Dr. Martiery Nalda, Inspire Weight Loss Lake Nona, FL or Inspire Weight Loss Franchises may use and/or reproduce such photographs and recordings.

I hereby release Dr. Martiery Nalda, Inspire Weight Loss Lake Nona and Inspire Weight Loss Franchises and any of its associated or affiliated companies, their directors, officers, agents, employees, customers and appointed advertising agencies, their directors, officers, agents and employees from all claims of every kind on account of such use.

If the Model is under 18 years of age: I, _____, am the parent/legal guardian of the individual named above. I have read and understand this release form and approve of its terms.

Print Name:_____**Signature:**_____**Date:**_____

CONTOUR LIGHT

You have requested treatment utilizing Contour Light LED light therapy. This treatment is the application of 635 nm (nanometers) and 880nm (nanometers) light, which causes the fat within the adipose (fat) cell to leave and accumulate in the interstitial space. This excess fat is removed by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform you of the nature of this product and its risk. LED therapies have been approved by the FDA.

Procedure

Initially you will consult with the Doctor/Health Coach to determine if you are a candidate for the LED therapy. You will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined that you are a candidate for this procedure, then paperwork, measurements, pre and post photos (upon your approval) and suggested course of treatment will be discussed with you. The treatment is administered by placing up to 6 LED pads on the desired area(s) to be treated. Most patients will need a **minimum of 12** treatments for the Light LED Therapy to achieve the most desired effect. This treatment should be used in conjunction with a healthy diet and exercise. You should consult with a healthcare professional before beginning any new exercise program to determine if your body is physically able to do so.

Risks/Discomfort

This treatment is non-invasive. During treatment there should be no discomfort. The client may feel the warmth of the light. Contour Light is suitable for anyone over 18 years of age who does not have any of the following issues:

Pregnancy, Breast Feeding, Recent Cancer, Heart Disease, Pacemaker or Metal Pins/Plates

Benefits

LED light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose (fat) before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted; however, the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials, patients have averaged 2-5cm loss from their stomach, hips, and thighs. These results vary and no guarantee is implied or suggested that desired results will be achieved.

VOLUNTARY COSMETIC PROCEDURE

_____(Initial) I understand that this is strictly a voluntary cosmetic procedure. No treatment is necessary or required and the Contour Light LED therapy has been chosen by myself (the client).

_____(Initial) I have been informed of the potential risks and side effects of the Contour Light including but not limited to redness, swelling, heat sensitivity, pain, increased bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand them.

_____(Initial) I understand that a minimum of 9-12 treatments are required to achieve results at an average BMI of 25-30. A BMI of over 30 (which is considered in the obese range) requires a specific strategy moving forward with the minimum recommendation of 24+ treatments. Each body is different and may require more or less treatments depending on the client's diet, exercise, metabolism and body type. I understand the treatment is most successful if I maintain a healthy diet and commit to an exercise program.

_____ (Initial) I know that if I gain weight after the treatment program, the results of the Contour Light may be reversed.

_____ (Initial) I understand that no guarantee has been made to me as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its content in full. I have had ample time to consider the information and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure. If at any time during the Contour Light procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate my session at my discretion.

_____ (Initial) I duly authorize technicians/staff to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite and skin tightening. I am aware that clinical results may vary depending on the individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. If I do not make an effort to address my diet and exercise, the results achieved may not be retained.

_____ (Initial) I have reviewed the consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form, I grant authority to perform the described treatment. The purpose of this procedure, risks, complications, and alternative methods of treatment have been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. Increased redness to the area for up to 12 hours may be experienced (although it is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

Whole Body Vibration Plate Exercise Risks

Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising. Vibration exercises use your body weight and gravity to its fullest potential. Please do not use a whole-body vibration plate or any other exercise device without getting approval from your doctor.

The device is not recommended if you are: pregnant, diabetic with complications such as neuropathy or retinal damage, have a pacemaker, recently underwent surgery, suffer from Epilepsy or Migraines, have herniated disks, spondylolisthesis, have cancer or tumors, have recent joint replacements, have metal pins or plates, or have any other concerns about your physical health. These contraindications do not mean that you are not able to use a vibration or other exercise device, but it is recommended that you consult with your physician first.

_____ (Initial) I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the client). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

WEIGHT LOSS

I understand that my use and consumption of any Weight Loss product or engaging in any weight loss program including the type that is to be used in conjunction with Inspire Weight Loss, have inherent risks to my health and well-being, including but not limited to, headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments. I understand as well that rapid weight loss of over 1-2 pounds per week is considered, by most in the weight loss community, to be excessive and may lead to ailments similar and in addition to those mentioned above. Therefore, I understand that my failure to follow the weight loss program exactly as described to me by my physician or chiropractor can result in severe temporary and/or permanent medical conditions in addition to those mentioned above.

I understand that I am not to use or consume any of the Inspire Weight Loss products if I am pregnant or think I might be pregnant.

I understand that, as a dietary supplement, Inspire Weight Loss has not been approved by the FDA or any Federal or State authority. I additionally understand that The Inspire Weight Loss Program is not meant to diagnose, treat or cure any disease or medical condition. I understand that I am to undergo participation in the Inspire Weight Loss Program only under Doctor/Certified Health Coach supervision. I also understand that I should consult with my doctor prior to starting ANY exercise or nutritional supplement program.

I understand that, if I experience any ailment, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments, I should immediately stop using or consuming the Inspire Weight Loss product and, if any symptoms do not resolve immediately, I should consult my physician or go to the hospital emergency room.

I hereby consent to, and assume the risks associated with, the use and consumption of Inspire Weight Loss product and agree to follow the recommendations and instructions of my physician. I further agree not to use or consume any Inspire Weight Loss product without the advice, counsel and recommendations of my physician.

I hereby release, discharge and agree to indemnify my physician(s), Dr. Martiery Nalda, D.C., Inspire Weight Loss, their agents, servants, employees, and affiliates from any and all liability, claims, causes of action and demands for personal or bodily injury or death that I or my personal representatives might have or might hereafter acquire through my use or consumption of Inspire Weight Loss products.

I understand there have been no guarantees made to me and that my personal adherence to the program as prescribed to me is paramount to my success in weight loss. I also understand that there are **NO refunds** after receiving my instructions, materials and supplements.

I state that I am of lawful age and legally competent to sign this aforementioned release, The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the Doctor/Certified Health Coach if there is any change in my health. I understand the terms herein are contractual and not mere recital. I have signed this document of my own free act. **Once again, I understand that once the supplements leave the office the program is NON-REFUNDABLE.**

Printed Name: _____

Signature: _____

Date: _____

INSPIRE WEIGHT LOSS

Medical Provider List

Reason Under care

Physician _____ _____

OBGYN_____ _____

Endocrinologist_____ _____

Orthopedist_____ _____

Rheumatologist_____ _____

Any other Health Care

Specialist _____ _____

I give permission for Inspire Weight Loss to reach out to my physician, informing them that I am under Inspire Weight Loss care and supervision for treatment during my time here on their program/s.

Yes_____ NO_____

Signature_____