



Thank you for your interest in starting a Medically Supervised Weight Loss program at Kilgore Quick Care! We were the first clinic in East Texas to offer this program, and we have had amazing results.

Please visit our clinic at your convenience to begin your journey to better health, no appointment is necessary. Our clinic is open Monday - Thursday from 7:30-5:00pm, Friday from 7:30-3:00 and Saturday from 9-1. Please note that for new weight loss visits, you must arrive no later than thirty minutes before closing. Our address is 401 E. Lantrip, Kilgore, Texas.

To expedite your visit, please print the attached forms and have them filled out before you visit our clinic. If you do not have access to a printer, we have the forms for you in our office. For the first visit, the cost is \$240 or \$250 depending on the treatment you select. This includes an office visit, labs and your first injection. We offer semaglutide which begins at \$40 a dose or tirzepatide which begins at \$50 a dose. At your first visit, the provider will discuss which option would be the best choice for you. We have the option for you to come to the clinic weekly for your injection and weigh in, at which you will only pay for your weekly injection. We also have an option to buy a vial of the medication and self-administer the doses in your own home. Please note that there is no charge for dose changes.

After six months of treatment, a follow up visit and labs are required. The visit is \$50 and the labs are between \$35 and \$70 depending on which labs are needed.

We hope to see you soon!



# MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

Current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Occupation: \_\_\_\_\_

My exercise routine: Activity \_\_\_\_\_ Minutes \_\_\_\_\_ Times/week \_\_\_\_\_

My tobacco/nicotine use: Current Former Never Quitting

Long term, I would like to maintain my weight at \_\_\_\_\_ lbs. (goal weight)

My regular doctor is: \_\_\_\_\_ Town: \_\_\_\_\_

Females - Date of Last Menstrual Period: \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

## Previous or Current Health Conditions I have had include:(circle all that apply)

High Blood Pressure	Diabetes	Sleep Apnea	Thyroid Problems
Depression	Anxiety	Asthma	Gout
Heart Disease	PTSD	COPD	Arthritis
Kidney Disease	Binge Eating Disorder	Acid Reflux	Fibromyalgia
Leg Swelling	Anorexia Nervosa	Irritable Bowel/Colitis	Osteoporosis
Bleeding Disorder	Bulimia	FattyLiver	Urinary Incontinence
Blood Clot	ADHD/ADD	Crohn's Disease	Polycystic Ovaries
Anemia	Bipolar Illness	Ulcerative Colitis	Menopause
Cancer	Alcohol/Drug	Liver/Gallbladder disease	Suicide Attempt
houEczema	Headache/Migraine	Stomach Ulcers	Other _____

**MEDICAL HISTORY (CONTINUED)**

**PAST SURGERIES:**

Type	Date
1.	
2.	
3.	
4.	
5.	
6.	

**CURRENT MEDICATIONS:**

Medication Name	Dose and Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

## Kilgore Quick Care Consent to Treatment/Health Care Agreement

**CONSENT TO TREATMENT:** I voluntarily consent to receive medical and health care services provided by Kilgore Quick Care physicians, advanced practice providers, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to the result or cure. I acknowledge that Kilgore Quick Care may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information. I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from Kilgore Quick Care, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

**RELEASE OF MEDICAL INFORMATION:** I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at Kilgore Quick Care including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information. I acknowledge that the "Notice of Privacy Practices" provides information about how Kilgore Quick Care and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand Kilgore Quick Care cannot be responsible for use or re-disclosure of information by third parties.

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** I agree to pay all charges for medical and health care services. No insurance is accepted.

**NOTICE OF PRIVACY PRACTICES:**

\_\_\_\_\_ (Patient's Initials) I have received or reviewed a copy of Kilgore Quick Care's Notice of Privacy Practices posted on the waiting room wall. A copy will be provided upon request.

I certify that I have read this form or it has been read to me.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Patient/ Legally authorized person

\_\_\_\_\_  
Date

## **MEDICARE & MEDICAID REQUIRED FORM**

### **1. Do you have MEDICARE?**

I hereby attest to the following:

\_\_\_\_\_ I (or my dependent) AM NOT currently enrolled in any type of Medicare plan, whether as a primary, secondary, or tertiary plan.

Or

\_\_\_\_\_ I (or my dependent) AM enrolled in Medicare or a Medicare plan, whether as a primary, secondary, or tertiary plan. I understand that the providers at Kilgore Quick Care have opted out of Medicare. I understand that Medicare rules require that I sign this private contract with Kilgore Quick Care that medical services will not be covered by Medicare.

### **2. Do you have MEDICAID?**

I hereby attest to the following:

\_\_\_\_\_ I (or my dependent) AM NOT currently enrolled in any type of Medicaid plan, whether as a primary, secondary, or tertiary plan.

Or

\_\_\_\_\_ I (or my dependent) AM enrolled in Medicaid or a Medicaid plan, whether as a primary, secondary, or tertiary plan. I understand that the providers at Kilgore Quick Care have opted out of Medicaid. I understand that Medicaid rules require that I sign this private contract with Kilgore Quick Care that medical services will not be covered by Medicaid.

X \_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## KILGORE QUICK CARE MEDICALLY SUPERVISED WEIGHT LOSS (If Applicable)

I, \_\_\_\_\_, authorize my Kilgore Quick Care physician(s), or advanced practice clinician(s) and/or whomever may be designated as the medical assistant(s), 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 behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction 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 medication product literature. I authorize Kilgore Quick care providers to hold and dispense my Tirzepatide or Semaglutide according to clinic protocol.

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 associated with remaining overweight are tendencies to have high and increasing higher 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 made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

**DO YOU HAVE: (Circle Yes or No)**

1. Personal history of Gastroparesis	Yes	No
2. Personal history of Multiple Endocrine Neoplasia syndrome type 2	Yes	No
3. Personal history of Pancreatitis	Yes	No
4. Personal history of Gallbladder disease / stones	Yes	No
5. Personal history of Hypoglycemia	Yes	No
6. Personal history of Acute kidney injury / abnormal kidney function	Yes	No
7. Personal history of Diabetic retinopathy	Yes	No
8. Personal history of Suicidal thoughts or attempt	Yes	No
9. Family or personal history of medullary thyroid cancer	Yes	No

**POSSIBLE ADVERSE REACTIONS TO GLP-1, GIP MEDICATIONS:**

- Anaphylactic/ allergic reaction and angioedema have been reported.
- Most common adverse reactions: nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, indigestion, dizziness, abdominal distention, belching, gas pain, acid reflux.

**WARNING:** May cause fetal harm. Discontinue semaglutide at least 2 months before planned pregnancy and immediately when pregnancy is recognized.

Patient Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_