KILGORE
QUICK CARE
HOMETOWN HEALTH & WELLNESS

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 one hour 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 $200 which includes an office visit and labs. Our options of weight loss peptides include semaglutide which begins at $30 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** new office visit charge for dose changes, however increasing dose does increase the price.

After six months of treatment, a follow up visit and labs are required. The visit is $50 and the labs are either $20 or $45 depending on which labs are needed.

We hope to see you soon!



New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL **Today's Date:** _____

Patient's Full Name:_____
First Middle Last

Birthday:_____ Gender: Male_____ Female _____
MM/DD/YYYY

Address: _____
City State Zip

Home Phone Number:_____ Cell Phone Number: _____

Email: _____

Emergency Contact: _____

Relation to Patient:_____Phone Number:_____

Preferred Pharmacy & Pharmacy Location: _____

Where did you hear about our clinic? _____

KILGORE QUICK CARE
Medically Supervised Weight Loss New Patient Registration

Name: _____ Date of Birth:_____

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. 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, Semaglutide, or Retatrutide 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

ADVERSE REACTIONS:

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

Patient Signature: _____ Date:_____

My Medical History (page 1 of 2)

Name: _____ Date of Birth:_____

Current weight: _____ Height: _____

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 to you)

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
Chronic 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
Eczema	Headache/Migraine	Stomach Ulcers	Other_____

List Previous Surgeries

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

Medical History (page 2 of 2)

***Prescription* Medications** I CURRENTLY take are:

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

_____ Date _____

Provider Signature

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

Kilgore QUICK CARE
401 E. Lantrip Street
Kilgore, TX 75662

MEDICARE & MEDICAID

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**

Release of Information

At **Kilgore Quick Care,** we respect your privacy and are committed to protecting your personal health information. This form allows you to identify individuals with whom **Kilgore Quick Care** may share information regarding your medical care, test results, and treatments.

Patient Name:_____ DOB: _____

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS (Yes or No):

☐ **YES**- I give Kilgore Quick Care permission to discuss my medical information with the individuals listed below:

1. Name:_____ DOB: _____

   Relationship:_____ Phone:_____

2. Name:_____ DOB: _____

   Relationship:_____ Phone:_____

3. Name:_____ DOB: _____

   Relationship:_____ Phone:_____

☐ **NO**- I do not give Kilgore Quick Care permission to discuss my medical information with family members, friends, or other individuals unless otherwise permitted or required by law.

Patient Acknowledgement:

I understand that my decision is voluntary and I may revoke a YES at any time in writing. I understand that individuals I authorize may share information they receive. This form does not prevent disclosures otherwise permitted or required by law. Kilgore Quick Care will verify the identity of any individual requesting patient information before releasing it.

X_____ _____/____/_____

Patient or Guardian Signature **Date**