WE ARE ALLURE

RIVERSIDE, CA
214 S Main St, Suite 101F
Duncanville, TX 75116
Phone: (833) 786-0516
Email: info@allurebtx.com

DUNCANVILLE, TX
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Duncanville, TX 75116
Phone: (833) 786-0516
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HEALTH HISTORY QUESTIONNAIRE

I.D. Verified:_____ Exp: _____

All questions in this questionnaire are strictly confidential and will become a part of your medical record.

Name (Last, First, M.I.): _____ Date of Birth:_____

Address: _____ City: _____ Zip Code:_____

Telephone: _____ Cell: _____ Email Address:_____

How did you find out about our facility? _____

DO YOU SUFFER WITH/FROM?

Please circle Yes or No

Anxiety - Yes / No
Depression - Yes / No
Suicidal/Homicidal Thoughts - Yes / No
Insomnia - Yes / No
Stress - Yes / No
Chest Pain - Yes / No
Headaches - Yes / No
Fatigue - Yes / No
Constipation - Yes / No
Swelling of hands or feet - Yes / No
Leg cramps - Yes / No
Dizziness - Yes / No
Difficulty Breathing - Yes / No
Diarrhea - Yes / No

PERSONAL HEALTH HISTORY

Surgeries:	Illness or Injuries:	Medications (currently taking):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HEALTH HISTORY

Please circle Yes or No

Cancer - Yes / No
Diabetes - Yes / No
High Blood Preassure - Yes / No
Heart Disease - Yes / No
Thyroid Disease - Yes / No
Kidney Disease - Yes / No

HEALTH HABITS AND PERSONAL INFORMATION

Please circle Yes or No

Exercise: None / Mild / Regular

Do you drink Alcohol? Yes / No

How much? _____

How often? _____

Do you use tobacco? Yes / No

How many cigarettes per day? _____

Do you have trouble losing weight? _____

How many times have you tried to lose weight _____

Drugs (street or recreational) Yes / No

What type? _____

Have you ever taken medication to lose weight? Yes / No

Patient Consent: I have read and understand the above and do hereby agree to the treatment administered to me, including medication for weight control.

Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
ALLURE MEDICAL WEIGHT CONTROL

I hereby acknowledge that I received a copy of David C. Stanford, M.D.'s Notice of Privacy Practices.

I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____ _____

Signature Date

_____ _____

Print Name Telephone

_____

Date of Birth

If not signed by the patient, please indicate relationship:

Check one:

- ☐ Parent or Guardian
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

_____

Name of the Patient:

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT
ALLURE MEDICAL WEIGHT CONTROL AND WELLNESS

Article 1: Agreement to ArbitrateIt is understood that any dispute as to medical malpractice — whether medical services were unnecessary, unauthorized, or improperly, negligently, or incompetently rendered — will be settled by arbitration under California law. This means you give up your right to a trial by jury or in court for such matters.

Article 2: All Claims Must Be Arbitrated This agreement applies to all claims or disputes, whether based on contract or other legal grounds, relating to treatment or services provided or not provided. It covers the physician, medical group, their partners, employees, or providers, as well as any patient, their pouse, heirs, or children (born or unborn).Even if the physician files a fee collection case, this does not waive the right to require arbitration for malpractice claims.

Article 3: Procedures and Applicable Law To start arbitration, a written demand must be sent by mail including the claim details, damages sought, and contact information. A neutral arbitrator (formerly a California superior court judge) will be selected. The process follows the California Code of Civil Procedure §§ 1280–1295 and the Federal Arbitration Act. Each party covers their own fees, plus a share of the arbitrator's costs.

Article 4: Retroactive EffectThis agreement also covers medical services provided before the date the form is signed, including emergency care.

Article 5: RevocationThis agreement may be revoked within 30 days by written notice. If not revoked, it applies to all services moving forward.

Article 6: Severability If part of this agreement is found invalid or unenforceable, the rest of the agreement will still apply.

Patient Acknowledgement I understand I have the right to receive a copy of this agreement.
By signing, I acknowledge that I have received one

NOTICE:BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU GIVE UP YOUR RIGHT TO A JURY OR COURT TRIAL.

By: _____ Date _____

Physician's or duly Authorized Representative Signature

By: _____ Date _____

Print or Stamp Name of Physician, Medical Group or Association Name

By: _____ Date _____

Signature of Translator (if applicable)

By: _____ Date _____

Print Name of Translator

By: _____ Date _____

Patient's Signature

By: _____

Print Patient's Name

_____

Patient's Representative's Signature (if applicable) (Date)

_____

Print Name and Relationship to Patient

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ALLURE MEDICAL WEIGHT CONTROL AND WELLNESS
REFUND POLICY

Refunds will be honored for valid medical contraindications only. These contraindications must be documented in writing by your primary care physician or other medical specialist where you are currently under their care. This documentation must be presented to our office no later than 30 days from your last purchase of such medications or supplements. The discount will pertain to the last credit purchased in your records within 30 days. In this instance, the discounted price will be voided. The medication or injections will be charged at the regular price and will be deducted from the remaining amount to your refund.

No refund credit for prior patients that have not been on the program greater than or equal to one year from their last visit.

No refund credit will be issued if there is evidence of omission or falsification on health history that results in the termination of any portion of the program.

_____ _____

Signature: Date:

Thank you for your cooperation

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ALLURE MEDICAL WEIGHT CONTROL AND WELLNESS
EKG PROTOCOL

Per our protocol here at ALLURE, and the guidelines of the American Medical Association and World Health Organization, anyone over or equal to the age of 45 will need to have an EKG annually prior to starting or resuming Phentermine or Phendimetrazine. Anyone under 45 yrs old with history of:

- Chest pain
- Shortness of breath
- Palpitations
- Fluttering
- Arrhythmias

If you have had a normal EKG within the past 12 months, please provide our office with a copy, and we will be able to move forward with the prescription weight loss program.

The cost for the EKG is $20. This amount is due when the services is rendered and whether the EKG is normal or abnormal.

You will be advised regarding the results and recommendations upon completion of the study

Signature: _____ Date: _____

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ALLURE MEDICAL WEIGHT CONTROL AND WELLNESS
INFORMED CONSENT FOR TREATMENT AND APPETITE SUPPRESSANTS

Patient Name (Print): _____ Date of Birth: _____

Your success depends upon your commitment to fulfilling your obligations during treatment. You should e willing to:

1. Provide complete answers to questions about your health. List all prescription and over the counter medications.
2. Devote the time needed to complete and comply with the course of treatment as prescribed.
3. Attend the weekly office visits and follow your recommended caloric intakes and exercise regimen.
4. Obtain blood/diagnostic test which your M.D. N.P or P.A deem necessary during your treatment.
5. Advise the medical staff of ANY concerns, side effects, complaints, symptoms, or any questions regarding your health and prescribed or over the counter medication.

Risks Associated with Being Overweight Conditions may include:

Hypertension, Diabetes, High Cholesterol, Asthma, Acid Reflux, Fatigue, Heart Attack, Stroke, Sleep Apnea, Arthritis, Polycystic Ovary Syndrome, and others. Many of these risks can be reduced or eliminated with weight loss.

Common Side Effects of Phentermine and Phendimetrazine:

Fast, Irrgular, pounding heart beat (pulse), Insomnia, Excessive thirst, headaches, trouble breathing, dizziness, constipation, skin rash, unpleasant taste, drowsiness, Anxiety/Depression, Restlessness, Tremors Impotence, Libido changes, Abdominal pain.

Gallstones & Pancreatitis

Overweight individuals are at a higher risk for gallstones, especially women, smokers, and those on estrogen. Rapid weight loss can increase this risk. Symptoms may include nausea, fever, vomiting, and upper right abdominal pain. Seek medical attention immediately if symptoms occur. Pancreatitis may also occur and could require surgery or medication.

Pregnancy Warning

Phentermine and Phendimetrazine should not be taken during pregnancy or while breastfeeding. If you become pregnant, stop the medication immediately and notify your doctor and OB/GYN.

_____ Initial

Your Rights and Responsibility:

- You may leave the program at any time
- You must inform your provider of any medical changes
- No guarantees are made about the outcome
- Continued weight management is necessary for long-term results

Dispensing & Drug Testing

- FDA-approved for short-term use (12 weeks)
- Medication will be re-evaluated after 12 weeks
- Long-term use may be allowed for those who benefit from it

About Appetite Suppressants

- Medications may be dispensed at the clinic or by prescription
- You are responsible for following dosing instructions
- If drug tested, you may test positive for amphetamines; you may request documentation confirming your prescription

Alternatives

Natural appetite suppressants are available for patients who cannot take prescription medications due to medical reasons.

Participant Signature: _____ Date: _____

I have explained the purpose, risks, and benefits of this program and answered the patient's questions.

Physician / Provider Signature: _____ Date: _____