

# SunCoastAI

## SUNCOAST AI WEGHT LOSS MANAGEMENT PROGRAM

### INTRODUCTION and PATIENT CONTRACT

Dr. Eriksen's Medical weight loss management program is supervised weekly to biweekly and includes medications, along with vitamin supplements which are all supervised. This way each patient's progress can be monitored and allow the patients to learn along the way how to maintain a healthy lifestyle once they are finished with the program.

Dr. Eriksen does not dictate what diet plan each patient must follow, the patient along with the guidance of Dr. Eriksen will incorporate important aspects from numerous diets involving increased protein, decreased carbohydrates and lowering overall calorie consumption allowing safe and healthy weight loss. Programs included are Ideal Protein, Adkins, and South Beach diets. Dr. Eriksen will work with each patient and decide what their goals are and depending on what amount of weight loss is necessary, work towards phases of weight loss. Each plan is created individually for the patient and there is flexibility along the way as plateaus are reached and some type of change is necessary.

We ask patients to come in for weekly visits and biweekly physician appointments. This way each patient's food diary and exercise diary can be reviewed. I encourage patients to write down any questions prior to their visit so they can be answered on the appointment day. The appointments will range in time from am appointments for medication refills and afternoon appointments for physician appointments.

Each appointment will entail weigh in, BP check and patients must show at least a 2 lb weight loss per week to maintain the medications. Patients must understand that this program will work with the support and knowledge given but it is ultimately up to the patient to follow through with the plan for reaching their goal weight.

When signing up for this plan, each patient has to be committed and willing to be responsible to themselves so they can achieve their weight loss goals.

Date: \_\_\_\_\_

Printed Patient Name: \_\_\_\_\_

Signed Patient Name: \_\_\_\_\_

Dr. Eriksen: \_\_\_\_\_

We would like to take "before" and "after" photos of each patient in order to see how you have progressed over the length of the program. Please sign below giving us consent to take your photos.

**I give my consent for Suncoast AI to take my "before" and "after photographs.**

Patients signature: \_\_\_\_\_

Date: \_\_\_\_\_



**SUNCOAST AI WEIGHT LOSS MANAGEMENT PROGRAM**  
**HIPPA COMPLIANCE**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

**Treatment, Payment, Healthcare Operations**

**Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. When treatment is provided, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. We may also need to obtain hospital records to facilitate in your care.

**Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. If ever a medical claim form is used to obtain payment from your insurance company, it will contain medical information such as a description of the medical service provided to you and the diagnosis used. Your insurance company needs this information to approve payment to us. We may also need to use your information for medical claim review or hearing if the review is denied in order to obtain payment for our services.

**Health Care Operations**

We are permitted to use or disclose your medical information for the purpose of health care operations which are activities that support the practice and ensure that quality care is delivered. A professional consultant may be used to ensure we are maintaining our compliance with the regulations and the law. In addition to this we may ask another physician to review this practice's charts and medical record to evaluate our performance so that we may ensure that only the best healthcare is provided by this practice.

**Disclosures That Can be Made Without Your Authorization**

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. This includes but is not limited to, fax transmissions. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization

**Public Health, Abuse, or Neglect and Health Oversight**

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for collection of information about disease, vital statistics (like birth and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or administrative decision maker or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena
- Pertains to a victim of a crime and you are incapacitated
- Pertains to a person who has died under circumstances that may be related to criminal conduct
- Is about a victim of a crime and we are unable to obtain the person's agreement
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect

**I have reviewed the HIPPA compliance form for the practice: Suncoast AI**

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_



**AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS  
FROM MEDICAL PROVIDERS**

I hereby authorize Suncoast AI, (the "Practice") to obtain any and all medical records concerning my care from any physician, hospital, or any other health care professional that has provided medical care to me in the past.

I also hereby authorize the Practice to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to my insurance company.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO  
INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal Government privacy rules implemented through the Healthcare Portability act (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give you authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ I hereby give my permission for the Practice to leave lab results on my answering machine.

\_\_\_\_\_ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## Daily Food Diary

Name:						Date:	
Meal	Food Items	Calories	Protein grams	Fat grams	Carb grams	Vitamins & Minerals	
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							