ReNew Medical Center
hA²cg Patient Health Record

***Today's Date*:**___/____/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Flyer ☐ Door Hanger ☐ Drove by ☐ Groupon/Living Social ☐ Other _____

Patient Information

Last:_____ **First:**_____ **Middle:** _____

Allergies (foods, medicines, other): _____

Birth Date: ____/____/_____ **Age:**_____ **Sex: M / F** **Email Address:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____**)** _____-_____ **Cell Phone: (**_____**)** _____-_____

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____**)** _____-_____ **Cell Phone: (**_____**)** _____-_____

Weight Loss Goals

What are your weight loss goals? _____

Primary Doctor Information

Name: _____ **Phone: (**_____**)** _____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Illness(es): Current health conditions. Check all CURRENT conditions.

☐ Weak/compromised immune system
☐ Graves Disease
☐ Currently on Chemotherapy
☐ Hypotension
☐ History of Heart Issues
☐ Type 1 or uncontrolled diabetes
☐ Hypertension w/2 or more meds
☐ Cancer not in remission
☐ Unstable Gout
☐ Pregnant or Nursing
☐ Tuberculosis
☐ Gallbladder colic
☐ Unstable Angina

☐ Controlled Diabetic
☐ Anxiety/Depression
☐ Electrolyte Imbalance
☐ Hypothyroid
☐ Recovering alcoholics/addicts
☐ Dehydration Issues
☐ Stable Hypertension
☐ Cardiac Arrhythmia

Patient Name: _____ Date:_____

☐ **alzheimers**	☐ **cystic kidney disease**	☐ **multiple sclerosis**
☐ **anemia**	☐ **eczema**	☐ **parkinson's disease**
☐ **arthritis**	☐ **fibromyalgia**	☐ **pneumonia**
☐ **asthma**	☐ **hepatitis**	☐ **psoriasis**
☐ **cerebral palsy**	☐ **influenzal pneumonia**	☐ **seizures**
☐ **chicken pox**	☐ **liver disease**	☐ **STD's (unspecified)**
☐ **crohn's/colitis**	☐ **lung disease**	☐ **suicide attempt(s)**
☐ **CRPS (RSD)**	☐ **lupus erythema *(discoid)***	☐ **vertigo**
☐ **CVA (stroke)**	☐ **lupus erythema (systemic)**	☐ **other: _____**

Other Info:

Smoker: Y/N How much? _____ Alcohol: Y/N Drinks per week? _____

Recreational Drugs: Y/N Type _____ Frequency _____

Coffee: Y/N Cups per day _____ Sodas: Y/N Type _____ Cans per day _____

Exercise: Y/N Type _____ Frequency _____

Are you currently receiving any health care? Y/N

What for? _____ From whom: Name _____

Address: _____ Phone: _____

I hereby acknowledge that the above information is true and correct to the best of my ability.

Print Name: _____ Signature: _____ Date: _____

ReNew Medical Center, LLC

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INFORMED CONSENT FORM FOR HA²CG PROFESSIONAL WEIGHT LOSS PROGRAM

I agree that to enter the **hA²cg weight loss program** I have completed an accurate and truthful patient history including any current medications and/or treatments I'm currently undergoing. I agree to any additional follow-ups with my primary care physician as directed by Dr. Schmidt or his staff while on the **hA²cg professional weight loss program**.

I agree and understand that because the remedies used in this new diet program are homeopathically based, and because the FDA hasn't certified HOMEOPATHIC HA²CG as a valid weight loss remedy, that this program is exempt from insurance coverage by my third party health insurance. I will agree to pay for these services outside of the third party payer systems.

- The new HA²CG product is registered as a proper Homeopathic product with the FDA-listed product (NDC # 57520-0751-1)

I agree that the Basic Program is as follows:

1. Reading the *hA²cg Success Guide* handbook provided with the program, especially noting the specific foods I can eat on the diet.
2. Attend a scheduled Consult Visit with Dr. Schmidt's staff to both perform a Proper Diet Intake Exam and discussion for the purpose of understanding the program. Measurements will be taken by Staff. Approx 30 minutes.
3. One office visit per week for weighing and measuring.
4. Take the 6 Bottle Detox Protocol (Cerebromax, Spinalmax, Matrix Support and Detox I, II, III). To be taken for the entire program.
5. Take the HOMEOPATHIC HA²CG Professional Formula drops as recommended: ten drops at a minimum of 3 times daily (approximately 4-6 week supply). The 23 day protocol will require one bottle and the 40 day protocol will require two bottles.
6. Maintain a diet diary in the Guidebook and bring it in for review if weight doesn't reduce as appropriate.
7. Follow the protocol for the three week Maintenance phase after you complete the HA²CG program.
8. For multiple cycles, follow the maintenance diet in-between rounds of HOMEOPATHIC HA²CG series if the program is done more than once (for additional weight loss).

Initials_____ Date _____

COST FOR THE PROGRAMS

	23 Day Program (up to 15 pounds)	40 Day Program (up to 34 pounds)
Initial Consultation	X	X
Success Guide, Pounds & Inches Books	X	X
Detox Sets of 6 bottles	X	X
HOMEOPATHIC HA²CG Bottle(s)	X	XX
Weekly Visits	X	X
Professional Weight Support	X	X
TOTALS	**$350**	**$450**

OPTIONAL ADDITIONAL SUPPLIMENTS

Supplements:	
Appetite Control	$25
Four Pillars Multi-Vitamins	$55
Chiro-Klenz Tea	$20

If any of the programs are cancelled for whatever reason, refunds will not be available nor is the program transferrable.

Initials_____ Date _____

I further recognize that Advanced Technology Chiropractic will be taking pre and post photos to track my progress and may use these photos upon my consent. You have my permission to use my before and after photos (initial) _____
Please do not use my before and after photos for any purpose (initial) _____

I further agree to ask questions when I do not understand the purpose of any procedures or medications. If I do not ask it can be presumed that I fully understand the protocol and accept any possible side effects that may occur while on the diet.

Alternative methods
I understand that there are other ways to lose weight and have after consideration decided to take the approach of the HOMEOPATHIC HA^{2}CG diet as outlined here.

Possible Side effects
I understand that the HOMEOPATHIC HA^{2}CG program can upset existing medical conditions such as Hypertension, diabetes, thyroid difficulties and post cancer conditions and agree to work closely with Dr. Schmidt and his staff to manage these conditions if I have them.

Potential Risks
I recognize as well that the extreme caloric part of the HOMEOPATHIC HA^{2}CG program can create symptoms such as hunger, constipation, reactivation of previously controlled health problems such as thyroid, hypertension and sugar imbalances and to work with Dr. Schmidt to manage any difficulties as further defined in the guidebooks and the Pounds and Inches manuscript of Dr. Simeon which I have agreed to read prior to starting this program.

I verify that I have read and initialed all of these pages and that my permission is freely given.

Patients Name

_____

Signature **Date**

Guardians Name

Signature **Date**