ProGenix
HEALTH SOLUTIONS, INC.

Metabolic Testing Patient Registration Form

Date: _____ **Name: _____**

Home #: _____ **Cell #: _____**

Address: _____
Street **City** **State** **Zip Code**

Email: _____ **Emergency Contact & Phone: _____**

How did you hear about us or who referred you? _____

***I consent to receive calls from ProGenix Health Solutions, Inc. for my protected healthcare and other services related to the service of my account at the phone number(s) above, including my cell number provided. Initial here _____**

General Health & Nutrition Questions

Personal Profile Information

Gender: ☐Male ☐Female Birth date: _____
Weight: _____ Height: ____ / ____

Medications

Are you currently taking any *prescription or over-the counter* medications? No____ Yes ____
Please list:

_____

_____

List any current medical conditions: _____
List any allergies to medications: _____

Goals and Expectations

What are your goals and expectations for treatment? (Please be as specific as possible)

_____

_____

_____

How likely are you to follow the necessary treatment and do whatever it takes to reach those goals?

☐ Not Very Likely ☐ Somewhat Likely ☐ Very Likely

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Weekly Exercise Information

Explain in detail what type of resistance exercises, cardiovascular or sports activities you perform on average during a 7-day period.

Exercise Activity	Days/week	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lifestyle / Professional Activity

How would you rate the activity level of your profession, or what you do during the day (non-exercise related)?

☐Sedentary ☐Moderately Active ☐Active ☐Very Active

Protein Requirements

Which best describes you?

☐Sedentary Adult ☐Exercising Adult ☐Competitive Athlete
☐Growing Teenage Athlete ☐Adult Building Muscle ☐Athlete Restricting Calories

Body Type

Which of the following best describes you?

☐I can eat practically anything I want and I do not gain weight. I find it hard to gain weight.
☐I can lose or gain weight by adjusting my activity level and eating habits.
☐I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Health & Medical Conditions

Check any that apply.

☐Heart Disease ☐Anemia ☐Hypoglycemia
☐Liver Disease ☐Kidney Disease ☐Diabetes
☐Pancreatic Disease ☐Lactation ☐Hypertension
☐Other: _____

Please list below everything you eat in one 24 hour period and approximate amounts. Be sure to include snacks and beverages, including water.

Time: _____ Food/Beverage: _____
Time: _____ Food/Beverage: _____
Time: _____ Food/Beverage: _____
Time: _____ Food/Beverage: _____
Time: _____ Food/Beverage: _____

List your favorite healthy foods:

_____
_____
_____
_____
_____
_____

List your least favorite healthy foods:

_____
_____
_____
_____
_____
_____

List any food allergies:

_____
_____

What time do you normally wake up? _____ What time do you normally go to bed? _____
Do you smoke? How many per day? _____ How many years have you smoked? _____
Do you drink alcoholic beverages? _____ How many drinks per day? _____
Please list any foods you are allergic to: _____
Have you ever been on a nutritional program before? If yes, by whom and what did it consist of?
_____
What were your results? _____
Have you ever had your body fat tested? If yes, how was it tested and when?
_____

Compliance and Agreement

I, _____ agree to allow _____ ___, weight management consultant, to design a weight management program to enhance my health and fitness goals. I will follow that program to the best of my ability, and I will not hold ___Progenix Health Solutions, Inc.___, or any related persons or parties, liable for any problems, illnesses, or injuries that might occur due to a sudden change in my eating habits. I understand that _____ is not a registered or licensed dietician, nor a medical practitioner. This weight management program does not replace the expert advice or medical treatment of my private doctor. I have given ___Progenix Health Solutions, Inc.___ all necessary information about myself in order to prevent any possible complications.

X_____ _____

Patient or Representative Signature Date

If this consent is signed by a personal representative of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

ProGenix
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Sellers (Consultant) and Purchasers (Patient)
Hold Harmless and Indemnification Agreement

I, _____ (the "Purchasers"), hereby warrant that I will indemnify and hold harmless _____ of ___Progenix Health Solutions___ and Lifestyles Technologies, Inc., (the "Sellers") and its officers, directors, agents, and employees. This indemnification and hold harmless warranty extends to Sellers, individually and separately, and the corporation's successors and subsidiaries against any and all claims, demands, actions, and causes of action, including personal injury, and all other liability whatsoever. This includes, but is not limited to costs, attorney fees, and/or judgments that arise out of the use of the DietMaster Pro Weight Management program.

The undersigned (the "Purchasers") further warrant the program is to be utilized within the State(s) of ___North Carolina___, and it will hold harmless and indemnify the Sellers corporation, its agents, directors, officers, employees, and individuals named in paragraph one of this agreement, against any and all claims for liability and/or damages, arising from any and all violations of Codes, Statutes, Licensing Procedures, Licensure Examinations, and/or Registration Requirements, of such states which govern the practice of dietetics, and/or weight management, and/or nutritional counseling, and/or advise, whether known or unknown, to the Purchasers at the time of purchase and subsequent use with the public of the DietMaster Pro Weight Management software program. Such indemnification includes, but is not limited to costs, attorney fees, and damages, whether reduced to judgment or not, and judgments which may arise from such claims, law suits, and/or administrative filings.

The indemnification includes all costs and attorney fees incurred by the Sellers in the investigation and defense of any claim enumerated in paragraphs preceding prior to a determination of an exact date of an occurrence and/or incident and/or violation upon which such alleged claims may be based.

It is further understood and agreed by the Purchasers, that the consideration for this Agreement, benefiting the Seller, its agents, directors, officers, employees, and the individuals named in the paragraphs preceding is the "weight management software content of the program".

Signature of Purchasers, confirms that the Purchasers have agreed to be bound by the terms of the Indemnification and Hold Harmless Agreement, and are contractually bound to indemnify the Sellers and its agents, directors, officers, employees, and the individuals named in paragraphs preceding, and such obligation includes the responsibility to pay any and all costs and attorney fees, which may be incurred by the Buyer in defending its agents, directors, officers, employees, and individuals named in the preceding paragraphs.

_____	*X*_____	_____
Patient Name (Print)	**Patient or Representative Signature**	**Date**
_____	*X*_____	_____
Consultant Name (Print)	**Consultant Signature**	**Date**

ProGenix
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Office Policies

We take great pride in the quality of care that we deliver. In effort to maintain this high-level of care, we have the following appointment policies in place. Compliance with these policies will allow all patients to receive treatment in a timely and efficient manner.

- Cancellation or Changes of an Appointment: In order to be respectful of the needs of other patients, please be courteous and call our office if you are unable to keep your appointment. If it is necessary to cancel or change your appointment, ***we require that you call at least 24 hours in advance.*** Your early cancellation will allow us to provide that time to another patient in need.

- Late Arrivals: I understand if I am late for my appointment, ProGenix Health Solutions, Inc. reserves the right to reschedule my appointment. We do our best to be prompt with our appointments so that our patients have very little wait time. If you are late to your appointment, we will do our best to work you in, but often our schedule does not allow for it.

- Missed Appointments: Cancellations without proper notice or missed appointments may be subject to fees. We realize that emergencies can come up; however, giving us as much notice as possible helps us better serve you and our other patients. It is vital to your treatment and health that you attend all your scheduled appointments. Appointments are in high demand and if you miss your appointment, we cannot guarantee that we will be able to reschedule you in a timely manner.

I have read and understand all of the office policies above. I understand that ProGenix Health Solutions, Inc. reserves the right to discharge a client who exhibits non-compliance with the treatment as prescribed; is uncooperative; does not follow medical advice; does not keep appointments; does not pay any balance due; or is disruptive or unpleasant to the staff.

X_____ _____

Patient or Representative Signature Date

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Informed Consent

I, _____, authorize ProGenix Health Solutions, Inc. to discuss/disclose information related to my treatment to the individuals listed below. This includes appointment scheduling, test results, current treatment, etc.

If I do not specify anyone, then I understand that no information will be released via phone, email or in person. If my spouse, or family member contacts ProGenix Health Solutions, Inc. by phone or email, and their name(s) is not listed below, they will not receive a return call/reply as this would verify that you are a client. This is for your privacy and protection.

We may call to remind you of your appointment or notify you of your test results. I agree to allow the doctor or office employees to identify themselves, as well as myself, to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

Name(s) of individual(s) that we are authorized to discuss/disclose your information related to your therapy:

_____

_____

_____

_____

_____ _____

Patient or Representative Signature Date

ProGenix
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Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

This practice's Notice of Privacy Practices is available to me and I understand it written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

X_____ _____

Patient or Representative Signature Date