Informed Consent for Prescription of Weight Loss

Pregnancy:
The appetite suppressants prescribed by Incredible Family Health & Wellness are Pregnancy Category C Drugs. This means there is uncertain safety in pregnancy. Even though no human studies have been performed, animal studies show an adverse effect. Therefore, we recommend that you use some type of contraception to prevent pregnancy DURING and FOR AT LEAST ONE MONTH AFTER you are on the appetite suppressants.

Nursing Lactation: The appetite suppressant prescribed by Incredible Family Health & Wellness is also "generally regarded as unsafe during lactation". Therefore, Incredible Family Health & Wellness you DO NOT BREASTFEED while you are on the appetite suppressants.
By signing this form, I acknowledge the receipt of the above information. I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions have not been answered to my complete satisfaction.

Patient Signature: _____ Date _____

Weight Loss Bill of Rights

WARNING:
Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss more than 1.5-2 pounds per week or weight loss more than 1% of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address, and qualifications of the dietician or nutritionist who has reviewed and approved the weight loss program according to s. 468-55(1)(j), Florida Statute.

I have read the above & A copy of the Weight Loss Bill of Rights has been given to me.

Patient Name: _____

Signature: _____ Date: _____

Weight Loss Consent and Disclosure

I, _____ hereby request and authorize Incredible Family Health & Wellness to perform an evaluation and treatment for participation in the weight management program. The goal of this weight management program is to perform a personalized weight loss regimen combining nutrition education, exercise, and when appropriate nutritional supplementation and appetite suppressant medications. I understand that my results may not be perfect. Each patient case is different, and the results and length of treatment will vary among individuals. I understand that although there are many health benefits to weight loss there also may be significant risks and complications associated with rapid weight loss, exercise and pharmaceutical agents. I have discussed my overall health and participation in the weight management program with my physician and I am willing to accept all of these risks, including death. I have discussed my concerns and questions with both my primary care physician and Incredible Family Health & Wellness provider(s) and have had everything answered to my satisfaction. I understand that one of the prescription medications used has an action similar to amphetamines which may include central nervous system stimulation and elevation of blood pressure. They are indicated as a short term adjunct in a regimen of weight reduction based on exercise, behavioral modifications, and calorie restriction. I understand that these drugs may be habit forming and will need to be tapered slowly upon cessation. **I understand that Phentermine is a controlled substance and I will not pass a drug screen (test), while taking this medication.** I understand that there is a lack of scientific data relating to the dangers of long term use of medicine. **I understand that the following are contraindications to the use of Phentermine and Phendimetrazine: a. Severe hypertension (high blood pressure) b. Severe arteriosclerosis (hardening of the arteries) or heart disease c. Hyperthyroidism d. Glaucoma e. Pregnancy or nursing mothers f. Allergy to this medication g. History of drug abuse: Concomitant use of guanethidine or if you have taken furazolidone or MAO inhibitor (eg, phenelzine within the last 14 days).I understand that some medicines may interact with the Phentermine and that I must notify Incredible Family Health & Wellness, if I am taking the following medications: a. Antidepressants, SSRIs or TRAMADOL because of the risk of high blood pressure, tremors, seizures, or irregular heartbeat may occur. I understand that the following side effects or complications from Phentermine may happen to me: a. Dry mouth, constipation, or diarrhea b. Nervousness c. Insomnia d. Headache e. Elevation of blood pressure f. Shortness of breath g. Tachycardia or rapid heartbeat h. Hives i. Dizziness, Syncope or fainting j. Primary Pulmonary Hypertension (PPH) k. Valvular heart disease. I understand that my weight loss medication is not to be shared with anyone. I understand that lost medication will not be refilled any earlier than anticipated.** I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the treatment. I also understand that the goal of this treatment is improvement, not perfection. I agree to keep Incredible Family Health & Wellness informed of any change of address so that the doctor can notify me of any new reports of late complications from this type of treatment, and I agree to be cooperative with Incredible Family Health & Wellness in my care until completely discharged. I understand that I have the right to request an itemized statement of my costs. I have read the above consent and fully understand the nature of this treatment and the risks involved. I acknowledge and understand that no expressed or implied warranty has been given to me. I have been given an opportunity to ask questions about the condition to be treated, the alternative forms of treatment, including no treatment at all, the procedures to be used, and the risks and hazards involved. All questions have been answered satisfactorily and I believe that I have sufficient information to give this informed consent. I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the

blank spaces have either been filled or crossed off, and that I fully understand its contents. I understand that if Incredible Family Health & Wellness judges at any time that my treatment should be postponed or canceled for any reason he/she may do so. I understand that I have the right to consult my pharmacist concerning the availability of a less expensive generically equivalent drug and the requirements of Florida law. I understand that treatment with weight loss medication is on a short-term basis only. I understand that the medicine given may lose its effectiveness over time. I understand that any successful weight loss program must involve diet, exercise, and lifestyle changes. I understand to maintain weight loss, diet and exercise must be continued part of my lifestyle. I hereby state that the information furnished toIncredible Family Health & Wellness during my comprehensive evaluation is correct and that I have disclosed all known medical conditions, allergies or adverse reactions to medical preparations. I agree to follow instructions given to me by Incredible Family Health & Wellness to the best of my ability before, during and after the treatment. I will notify Incredible Family Health & Wellness in a timely manner, any questions and conditions that may arise.

Patient Name: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Patient Requirements:

We require that our patients commit to evaluations. All weight management clinical studies show that this is a key ingredient to your success. This is also to inform you that the medications dispensed to you during your weight loss program are FDA-approved appetite suppressants. They are controlled substances and as such are highly regulated by state and federal agencies. We undergo periodic evaluations by the Florida Department of Health to assure compliance with these laws. The provider will always see you if there is a problem. Medication is reviewed at each visit, according to the statutes. We appreciate your patience if there is a slight delay during the checkout process. The success of your weight loss program can be limited if you decide to take this medication in any way other than prescribed. We assume that you will keep us updated on any changes in your medications or health status each visit. The sharing of these medications is absolutely forbidden and can be extremely dangerous. These medications can have severe side effects if certain medical conditions are present. Thank you for your cooperation!

Patients Signature: _____

Date: _____