

INFORMED CONSENT - GENERAL WELLNESS PROGRAM – PHI CLINIC

Patient Information

Name: _____

Date of Birth:

Date: _____

Phone #:

Purpose of the Wellness Program

I understand that the PHI Clinic Wellness Program is designed to support overall health and well-being and may include, but is not limited to:

- Weight management services
- Nutritional counseling
- Injectable therapies such as GLP-1 medications (e.g., semaglutide, tirzepatide), Vitamin B12, and NAD+
- Lifestyle and preventive health recommendations

I understand that these services are not intended to replace primary care or specialty medical care.

Medical Evaluation

I acknowledge that prior to participation, a medical evaluation may be performed, including review of my medical history, medications, allergies, vital signs, and laboratory tests when indicated. I understand that participation is based on clinical judgment and medical eligibility.

Potential Benefits

Potential benefits may include improvement in metabolic health, energy levels, body composition, and overall wellness. I understand that results vary between individuals and that no specific outcomes are guaranteed.

Risks and Side Effects

I understand that wellness treatments and injectable therapies may carry risks, including but not limited to:

- Injection site pain, redness, bruising, or swelling
- Gastrointestinal symptoms (nausea, vomiting, diarrhea, constipation)
- Headache, dizziness, fatigue
- Allergic or adverse reactions, which may be rare but serious

I understand that not all risks can be predicted and that unexpected side effects may occur.

Patient Responsibilities

I agree to:

- Provide accurate and complete medical information
- Follow treatment instructions and dosing recommendations
- Report any side effects or concerning symptoms promptly
- Inform the provider of any changes in my medical condition or medications

No Guarantee of Results

I understand that PHI Clinic makes no guarantees regarding results or outcomes of the wellness program.

Voluntary Participation

I understand that participation in the Wellness Program is voluntary and that I may discontinue participation at any time.

Consent

I have read and understand the information above. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I voluntarily consent to participate in the PHI Clinic Wellness Program.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____