Medi-Slim Wellness

Lose Weight. Lose Inches. Get Fit

Patient Information

Name: ---------- *D.O.B:* __/__/__ *Age:*_____ *Date:* __/__/__.

Address----------

Home phone ( ) ---------- *Cell phone ( )* ----------

Who referred you? _____

- **DO YOU CURRENTLY HAVE:** Gout, Kidney failure, Glaucoma, Gallstones, HIV/AIDS /----------
- Hepatitis C / Heart disease or allergic to protein. **Diabetes**: Type1 / Type2 ----------
- **MEDICAL HISTORY:** constipation / depression / palpitations / insomnia/ eating disorder----------
- **PAST MEDICAL OR SURGICAL HISTORY:** None /----------
- **SOCIAL HISTORY:** (please Circle) Smoking / Alcohol / Illicit drug Abuse? None

- **CURRENT MEDICATIONS:** None /----------
- **PRIOR MEDICATIONS FOR WEIGHT LOSS:** None /----------
- **ALLERGY :** - ***Sulfa:*** Yes / No - ***Other****: None/*----------

- **PAST EXPERIENCE WITH DIET & EXERCISE?:** Yes / No
  If yes, how long ----------Did you get results? Yes / No
- **YOUR GOALS:** Lose weight ( ) lbs/ Eat healthy/ Get in shape/ Other ----------
- **CURRENT PHYSICAL ACTIVITY LEVEL:** High / Moderate / Low

- **ARE YOU CURRENTLY BREASTFEEDING:** Yes / No
- **CURRENT PRIMARY CARE PHYSICIAN:** ----------

HOW DID YOU HEAR ABOUT US? (Check all that apply)

○ Our Website	○ Shopping Guide	○ Internet Search
○ Drive-by	○ Friend / Relative	○ Yelp.com

(Optional)

Would you like to be notified of upcoming sales and promotions by email?

[ ] Yes [ ] No

***Email address** (Please Print):*_____@_____

MEDI-SLIM WELLNESS PATIENT AGREEMENT

Your success depends upon your commitment to understanding and fulfilling your obligations in a course of treatment. The purpose of this agreement is to ensure that you are making the commitments necessary to allow Medi-Slim Wellness to be able to assist you. Please initial each paragraph and sign below.

1. You, as a patient, agree to provide honest and complete answers to questions about your health, weight problem, eating activity and lifestyle patterns so your healthcare professional can better understand how to help you.
2. You agree to devote the time needed to complete and comply with the course of treatment your healthcare professional has outlined for you, including assessment, treatment, and maintenance phases.
3. You agree to work with your healthcare professional and others who may participate in helping you manage your weight loss, including keeping a daily diary and following your diet and exercise prescription.
4. You agree to be under the care of a primary care physician outside of the specialty medical weight loss care provided by Medi-Slim Wellness physicians and to provide his or her information to Medi-Slim Wellness. You agree to allow your Medi-Slim Wellness healthcare professional to share information with your personal physician. If you do not have a personal physician, you must agree to find one before you and Medi-Slim Wellness begin working together.
5. You agree to make and keep follow-up appointments with your physician and have any blood tests taken or any other diagnostic measures made that your physician may deem necessary during your course of treatment.
6. You agree to follow your exercise program within the guidelines given to you by your healthcare professional and your physician.
7. You agree to disclose to Medi-Slim Wellness all medication, care, treatment, diagnoses, and assessments that I receive elsewhere and to provide medical records from other providers to ensure that care is coordinated and compatible.
8. You agree to advise the Medi-Slim Wellness clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the healthcare professional and/or your physician can determine if you require other attention. You acknowledge that keeping Medi-Slim Wellness informed of any questions or symptoms you have affords the best chance of intervening before a problem becomes serious.

9. You agree to notify a Medi-Slim Wellness physician regarding any changes in medications or in your medical status, and of any adverse effects you experience from any of the medications that you take.
10. Medi-Slim Wellness has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
11. You may not share, sell, or otherwise permit others to have access to medications.
12. You agree to discontinue the program if you suspect that you may be pregnant.
13. Prescriptions and bottles of these medications may be sought by other individuals. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
14. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effect, especially a child, you must keep them out of reach of such people.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. The risks and potential benefits of medical weight loss are explained elsewhere. You acknowledge that you have received such explanation.
17. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all its terms.
18. **Refund Policy:** No refund or exchange for all consumable products or services. For "*discounted packages*", a store credit will be issued for any remaining balance equivalent to (actual paid discounted price minus the sum of the full regular price of any consumed products or services).

Your signature below represents your permission, understanding and commitment to the above.

Physician/PA Signature: _____ Date: _____

Patient Signature: _____ Date: _____

INFORMED CONSENT - Appetite Suppressant Therapy (Phentermine)

This is an informed-consent document that has been prepared to help inform you medical use of the appetite suppressant Phentermine, its risks, and alternative treatment. It is important that you read this information carefully and completely before signing the consent below.

INTRODUCTION.

1. I have authorized Medi-Slim Wellness and its physicians to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of an appetite suppressants known as Phentermine. I understand that the use recommended by Medi-Slim Wellness and its physicians may exceed 12 weeks, which is the short-term period of use recommended by the Food and Drug Administration (FDA). I understand that this use for longer than 12 weeks is considered an "off-label" use, which is based on the belief of Medi-Slim Wellness physicians that appetite suppressants may be helpful for longer periods. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below). I understand that, in order to continue taking appetite suppressants, I must come to be seen by a Medi-Slim Wellness physician every 12 weeks.

RISKS

Before I begin this treatment program, I have been made aware of the following side effects and risks associated with the use of this medication:

2. Appetite suppressants have some negative side effects and risks. Medi-Slim Wellness physicians believe these side effects and risks are outweighed by the benefit of the appetite suppressant use to address other health risks. I understand the purpose of this treatment is to assist me in decreasing body weight and maintaining weight loss. I understand that my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. However, as a patient, I must decide if I am willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants used in this manner may give. I understand that it is my responsibility as a patient to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that may be related to my weight control program as soon as reasonably possible.

Common side effects of this medications may include bad taste in mouth; changes in sex drive; constipation; diarrhea; difficulty sleeping; dizziness; dry mouth; exaggerated sense of well being; headache; impotence; nervousness; overstimulation; restlessness; sleeplessness; upset stomach. It usually takes several (5-7) days for a person to get an idea how he/she is affected. Sometimes, these effects diminish in a few days, but sometimes they persist.

Certain **severe side effects** occur infrequently but require immediate medical attention if they occur. These include severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue); bizarre behavior; chest pain; _fainting; fast heartbeat;

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pounding in the chest; shortness of breath; swelling of the legs and feet; tremor. If any of these side effects occur, please seek emergency medical attention right away.

Other risks: Cardiovascular adverse effects may be associated with phentermine. Phentermine generally causes a significant rise in heart rate. Hypertension and arrhythmias may be problematic in susceptible patients. Vavular heart disease has also been reported. These and other possible risks could, on occasion, be serious or fatal.

Some of the side effects noted above are related to the fact that Phentermine produces nervous system stimulation, which may result in tremor, anxiety, restlessness, dizziness, insomnia, euphoria, dysphoria, and headache. Rarely, psychotic episodes have been reported.

4. Risk of physical dependence or addiction is high with Phentermine. In other words, with ongoing use of this medication, my body will get used to it. If I stop taking the medication abruptly, my body may react adversely with withdrawal symptoms, which may include: excessive tearing, runny nose, dilated pupils, "goose pimple" flesh, sweating, yawning, diarrhea, muscle aches, headache, and insomnia. To prevent these uncomfortable symptoms I should take my medication regularly and communicate to my physician any side effects. When discontinuing use of the medication, I should do so under supervision of my physician. Communication with my physician is necessary for me to understand the role of the medications in my weight loss program and to avoid development of this type of dependence.

5. Risk to unborn children: If I am a female of childbearing age and become pregnant, there is the risk that any child born will likely be physically dependent at birth. I understand that I am encouraged to maintain safe and effective birth control while in this program. If I become pregnant, I should immediately contact my physician so that medication will be tapered and stopped. If I am of child-bearing age and I am planning a family, I should contact my physician immediately.

6. **Evaluation of Treatment**:
Evaluation by clinic visit will assess: (1) how effective the appetite suppressant therapy is working, in conjunction with a comprehensive program of diet and exercise functions; (2) any adverse effects I've experienced (excessive sedation, constipation, worsening depression); and (3) accidental or purposeful medication misuse/abuse. Each evaluation will be documented in my medical record. If there is no improvement of weight loss or if I experience bothersome side effects, the medication will be tapered and discontinued.

7. **Benefits:** I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am. If Phentermine combined with diet and exercise, helps me reduce that risk by losing weight and maintaining weight loss that is a benefit. _____

8. **Alternatives.** I have been advised that there are alternatives to appetite suppressants. I have been advised about the alternative of non-pharmaceutical therapies and modalities for weight loss. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

I certify that I have had an opportunity to read and fully understand both pages of this informed consent. I also state that I speak, read, and write in English. My questions regarding side effects and risks have been answered by the doctor. I have had the opportunity to and have been encouraged to seek a second opinion. The information which I have been given has been in terms clear to me, and I understand and accept the risks and complications of the treatments. My questions have been fully and completely answered for me, and I have read this document and understand all of its contents.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR MY MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

_____	_____	_____
Patient's Name **(PRINT)**	Patient's Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

I have explained this Consent, answered all of the patient's questions, and informed the patient of the known risks and available alternatives. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

Mohamed Ali, M.D.

_____	_____	_____
Physician/PA Name	Signature	Date