Bee You Be Empowered, LLC
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WEIGHT LOSS PROGRAM

INFORMED CONSENT

I request strict dietary restrictions for the purpose of weight loss. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through _____ I agree that I am and will be under the care of another medical provider for all other conditions. _____ can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand _____ can only prescribe weight loss related medication necessary for this treatment and all other health matters should be through my regular physician (s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as pregnancy, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalessemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure. Initials:_____

There are side effects that can office but not limited to:

- **Ovarian Hyper-stimulation Syndrome (OHSS) – which is a life-threatening condition**
- Arterial Thromboembolism - another potentially life-threatening condition
- Blood clots
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- **Hair Loss**
- Over stimulation of the ovaries causing production of many ova (eggs) in women
- Tiredness and/or weakness
- **Change in Moods**
- Irritation or skin rash in area of use
- Chest pains
- Low sex drive, Inability to have or keep an erection
- Blurred vision or temporary blindness
- Convulsions
- **Acne**
- Bleeding/Bruising
- **Excessive fluid retention in the body tissues, swelling (edema), numbness/tingling, trembling**
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- Prostate hypertrophy
- Abnormal enlargement of breasts in men (gynaecomastia)
- Difficulty breathing
- Fast, irregular, pounding or racing heartbeat or pulse
- Headaches
- Dizziness
- Unusual Sense of Wellbeing
- Mental Changes
- Hives, Skin Rashes
- Troubled with speaking
- Difficult or painful urination
- Collapse/Fainting
- Death

I understand weight loss treatments may involve these risks and other unknown risks: Initials:_____

I understand that weight loss treatments are absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. _____ if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. Initials:_____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this. Initials:_____

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact Dr. immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility. Initials:_____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise Dr. at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. Initials:_____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient's Name Printed:_____

Patient's Name Signed:_____Date:_____

Provider's Name Printed:_____

Provider's Name Signed:_____Date:_____