CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment, you provide a 24-hour notice. Appointments which are cancelled within less than 24-hour notice may be subject to $30 non-refundable fee. Payment owed must be paid at the time of cancellation. Cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Medical Stop, L.L.C understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date

SEMAGLUTIDE/TIRZEPATIDE CONSENT FORM

This document is intended to serve as a confirmation of informed consent for compounded Ssemaglutide & Tirzepatide which is a prescription weight management medications.

A. Patient Informed Consent

1. I voluntarily request that Medical Stop, L.L.C provider treats my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. I understand the mechanism of action of the medication.
5. I understand how it is to be administered.
6. I understand the prescription will come from a compounding pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.
7. Prices may vary and change. My charge will include my time with Medical Stop, L.LC (in person and via communication outside of the office), supplies, and medication.
8. Medical Stop, L.L.C may change the pharmacy based on several factors (availability, shipping time, cost).
9. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
10. I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects, and that death is also a possibility of taking this medication. I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medication.

Common side effects include, but are not limited to:

- Gastrointestinal: Nausea/vomiting, abdominal pain, Diarrhea/constipation, dyspepsia, abdominal distension, eructation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase.
- Neurological: Headache, dizziness
- Cardiac: Heart rate increase, Hypotension
- Endocrine: Fatigue, hypoglycemia (diabetic patients), alopecia
- Ophthalmic: Retinal disorder (diabetic patients)
- Skin: redness or pain at injection site

Serious Reactions include, but are not limited to:

- Thyroid C-cell tumor (animal studies)
- Medullary thyroid cancer
- Hypersensitivity reaction
- Anaphylaxis
- Angioedema
- Acute kidney injury
- Chronic renal failure exacerbation
- Pancreatitis
- Cholelithiasis
- Cholecystitis
- Syncope

B. **I understand that I have the following responsibilities.**

I agree to obtain medications for compounded Semaglutide or Tirzepatide only from Medical Stop, L.L.C. Medical Stop, L.L.C. Medical Stop does NOT accept nor file for any medical insurance or medical insurance claims reimbursement for coverage.

2. Medical history: I will tell Medical Stop, L.L.C my complete medical history, including: allergies, medications, medical surgical / social/family history.

a. Medical Stop, L.L.C may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).
b. I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
c. I will be honest to the best of my ability the history she needs to know.
d. I will tell my provider any updated health information (medication, allergies personal, medical issues/surgeries/social history, or family history changes).
e. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
f. I will always tell other providers about all medications I am taking.
g. Medical Stop, L.L.C may ask for me to seek additional labs while on treatment to ensure its safety. LAB FEES ARE PATIENT RESPONSIBILITY.LAB FEES ARE NOT COVERED BY MEDICAL STOP, L.L.C NOR INCLUDED IN MEDICAL STOP FEES.

3. Directions for use: I will take my medications only as prescribed according to the directions, led by Medical Stop, L.L.C.

a. If I feel my medications are not effective (after 30 days), or are causing undesirable side effects (immediately), I will contact Medical Stop, L.L.C for instructions.
b. I will not adjust my medications without prior instruction to do so.
c. I understand that the medication must be kept refrigerated.
d. I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will NOT inject any less than 7 days unless directed by Medical Stop, L.L.C (example: travel).
e. I will not share needles and will dispose of needles safely.
f. If I'm having troubles with the administration of the medication, I will seek help from Medical Stop, L.L.C.
g. The medication expires after 12 weeks. I will refer to the Beyond Usage Date (BUD).

4. Refills:

a. All refills will require an appointment.
b. I understand, I may need to schedule refill appointments ahead of time to avoid delays in refills.
c. Refills will get ordered Monday.
d. I will not ask for early refills.
e. I understand that I may be asked to bring the medication with me to my appointments to check the quantity left or assess how I am injecting.
f. **MEDICAL STOP RECOMENDS 6 MONTH PROGRAM FOR EFFECTIVE WEIGHT LOSS RESULTS**

5. Safety:

a. I understand it is important to keep my medication away from children (<18 years old)
b. I am the only one who will use my medication. I will not give or sell my medication to anyone else.

6. If Medical Stop, L.L.C deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

C. Discontinuation of medication: I understand that Medical Stop, L.L.C may stop prescribing my medications if:

a. I am having unfavorable side effects or it's not working to treat my medical condition.
b. I have been untruthful in my medical or family history.
c. I do not follow through with the recommended plan of care set by Medical Stop, L.L.C.
d. I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. It has been explained to me. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

Signature

Date

AUTHORIZATION /VIRTUAL PHONE APPOINTMENTS & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

- I authorize to receive calls from Medical Stop, L.L.C for Virtual / Phone medical appointments. During this appointment. with Medical Stop, LLC, personal medical information will be discussed.

I fully understand that my signature is consent and authorization to be examined by Medical Stop, L.L.C.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____