Dr. H. Bui, M.D.

WEST PARK
Primary Care
936-328-5820 • 936-328-5824

Dr. E. Kanaan, M.D.
Richard Cain, N.P.

WPPC Medical Weight Loss Program Intake Form

Patient Name: (Last) (First) (MI)

_____

Patient Address:_____ City: _____State: _____Zip:_____

Phone Number: _____Email: _____

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name:_____ Relationship: _____

Phone: _____

How did you hear about us?_____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above. Sign:_____

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

Any past surgeries and hospitalizations? *

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

Personal History

What are your main interests and hobbies?

What is your line of work or study?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

You have problems falling or staying asleep?

How many hours do you sleep?

Do you wake up refreshed?

How is your energy?

Does your energy level affect your daily activities?

How would describe your mood, generally:

Does your mood affect your life or daily activities?

How would you describe your stress level?

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

Diet and lifestyle

Do you regularly drink alcoholic beverages?

_____ N

If yes, how many per week?

_____

Do you smoke tobacco?

_____ N

Do you use recreational drugs?

_____ N

How is your appetite?

_____ Good, Fair, Healthy Or always Hungry (Circle)

Snack Habits:

What:

How much:

When:

Typical Breakfast:

What:

How much:

When:

Typical Lunch:

What:

How much:

When:

Typical Dinner:

What:

How much:

When:

How often do you eat out?

What restaurants do you frequent?

How often do you eat "fast foods"?

Food allergies?

Food dislikes?

Food cravings?

Do you eat because of emotions (explain)?

Do you drink coffee or tea? Yes No If Yes, how much daily?

Do you drink pop / soft drinks? If yes, how much?

Do you use sugar substitutes?

What are your worst food habits?

How much fluids do you normally drink? Please approximate in ounces.

Please list all types of beverages you regularly drink.

Please list any food allergies, intolerances, or foods you avoid and the reason.

What past struggles and difficulties have you experienced in terms of food and dieting?

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

What types of diet and exercise approaches have worked for you in the past?

And what hasn't worked for you at all?

When did you first become overweight?

How did your weight gain start? Describe any circumstances:

What do you think is the cause of your weight problem?

What was your highest weight? (excluding pregnancy)

What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How MOTIVATED are you to lose weight?

Is there anything else you would like to tell us?

Please list the factors you feel have contributed to your current weight (check all that apply):

- Slow metabolism ☐
- Family history of obesity ☐
- Comfort food dependency ☐
- Lack of exercise ☐
- Binge eating ☐
- Late night snacking ☐
- History of trauma ☐
- History of grief and loss ☐
- Medication related weight gain ☐
- Significant restrictive eating behaviors like anorexia ☐

Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
Fatigue	○	○	○	○
Unexplained weight loss or gain	○	○	○	○
Change in appetite	○	○	○	○
Depressive symptoms	○	○	○	○
Anxiety	○	○	○	○

Mood swings	○	○	○	○
Nervousness	○	○	○	○
Addictive dependency	○	○	○	○
Disordered Eating Pattern/Tendency	○	○	○	○
Tension	○	○	○	○
Lack of mental focus	○	○	○	○
Thyroid problems	○	○	○	○
Diabetes	○	○	○	○
Blood sugar irregularities	○	○	○	○
Excessive thirst or hunger	○	○	○	○
Sugar cravings	○	○	○	○
Abnormal hair growth	○	○	○	○
Excessive perspiration	○	○	○	○
Feeling excessively hot or cold	○	○	○	○
Headache	○	○	○	○
Lightheadednes	○	○	○	○
Joint pain or stiffness	○	○	○	○
Muscle weakness or soreness	○	○	○	○
High blood pressure	○	○	○	○
Heart murmur/palpitations	○	○	○	○
Cold or pale extremities	○	○	○	○
Asthma	○	○	○	○
Short of breath	○	○	○	○
Heartburn	○	○	○	○

Abdominal discomfort after eating	○	○	○	○
Nausea	○	○	○	○
Abdominal bloating	○	○	○	○
Belching/gas	○	○	○	○
Constipation	○	○	○	○
Diarrhea	○	○	○	○
Daily bowel movements	○	○	○	○

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WPPC Clinical Policies

PATIENT CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT WITH WPPC.

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at WPPC. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____Phentermine and Vyvanse are considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

_____I understand that treatments used at WPPC might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

_____I understand that having an appointment with WPPC does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

_____I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that WPPC manages my treatment and it is at their discretion to provide

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with WPPC in regards to weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

_____I do not hold any medical practitioner of WPPC responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold WPPC or any provider harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to WPPC as this could change the treatment prescribed to me.

I have read, understand and agree to all of the above statements.

Print Name:_____

Signature:_____Date_____

WPPC

Informed Consent for Medically Management Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with WPPC. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

1. **Cardiovascular (heart or blood pressure):** These problems may include heart palpitations, irregular beats, or rapid heartbeat. These effects are usually mild but can result in serious problems including heart attack or stroke. Also, these medications may increase blood pressure, which if left untreated can lead to heart attack or stroke. If you discontinue the weight loss medication, the elevated blood pressure usually resolves. For this reason, if you are on blood pressure medications you are required to monitor your blood pressure daily and discontinue medications if blood pressure rise, your heart rate increases, or you feel palpitations. (Please initial) _____

2. **Sudden Death:** Patients with morbid obesity, particularly those with hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient. (Please initial) _____

3. **Reduced Potassium Levels:** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids, nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in electrolytes, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential. (Please initial) _____

4. **Gall Bladder Disease:** Any program resulting in rapid weight loss may precipitate the formation of gallstones, which could lead to cholecystitis (inflammation of your gallbladder), which is a medical urgency or emergency and could require surgery. This is typically because of the rapid weight loss, not the medications you are taking. Symptoms include right upper abdominal pain, abdominal just below your ribs, nausea, and vomiting. (Please initial) _____

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Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact WPPC at 210 W Park , TE 104, Livingston Tx 77351 @936-328-5820 at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party "business associates" such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Research; We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

WPPC

210 W Park Ste 104, Livingston Texas 77351 @ 936-328-5820

Please sign and date indicating you have read and understand you're Patient Rights.

Name_____Date_____

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Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by WPPC and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by WPPC;; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by WPPC;; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by WPPC;. I am aware of the potential side effects associated with weight loss therapy, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

210 West Park Dr. Suite 104 • Livingston, Texas 77351
www.westparkprimarycare.com

WPPC

Informed Consent for Medically Management Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with WPPC. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

1. **Cardiovascular (heart or blood pressure):** These problems may include heart palpitations, irregular beats, or rapid heartbeat. These effects are usually mild but can result in serious problems including heart attack or stroke. Also, these medications may increase blood pressure, which if left untreated can lead to heart attack or stroke. If you discontinue the weight loss medication, the elevated blood pressure usually resolves. For this reason, if you are on blood pressure medications you are required to monitor your blood pressure daily and discontinue medications if blood pressure rise, your heart rate increases, or you feel palpitations. (Please initial) _____

2. **Sudden Death:** Patients with morbid obesity, particularly those with hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient. (Please initial) _____

3. **Reduced Potassium Levels:** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids, nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in electrolytes, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential. (Please initial) _____

4. **Gall Bladder Disease:** Any program resulting in rapid weight loss may precipitate the formation of gallstones, which could lead to cholecystitis (inflammation of your gallbladder), which is a medical urgency or emergency and could require surgery. This is typically because of the rapid weight loss, not the medications you are taking. Symptoms include right upper abdominal pain, abdominal just below your ribs, nausea, and vomiting. (Please initial) _____

5. **Pancreatitis:** Pancreatitis, or an infection in the bile ducts, may be caused by gallstones or the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death. (Please initial) _____

6. **Psychiatric:** There are reported cases of "hysterical or psychotic reactions" associated with the use or discontinuation of some of the drugs utilized for weight loss purposes. These reactions are extremely rare. (Please initial) _____

7. Men over 40 and post-menopausal women in general, and patients with risk factors for cardiovascular disease should have a cardiovascular evaluation before entering a medically managed weight loss program. This may include an ECG, a stress test, or other testing procedures, as per the discretion of a cardiologist. If you are over the age of 40, post-menopausal (female), smoke, have a history of high blood pressure, high cholesterol or you are diabetic, you acknowledge that you have had a cardiac evaluation and that you have been cleared medically prior to starting this weight loss program. (Please initial) _____

8. Common, but troublesome side effects may include but not be limited to dry mouth, palpitations, "speedy" feeling, headaches, sleeplessness., Rash, fever, nausea, vomiting, allergic reactions, decreased insulin sensitivity, flushing, headache, fatigue, lightheadedness, abdominal cramping, joint pain, fluid retention, and additional side effects not listed that will be discussed during your evaluation with WPPC. These side effects are generally rare, and most patients tolerate treatment without an issue. Please initial) _____

9. Drug interactions may occur if other medications are taken. Therefore, I will check with my prescribing medical provider before starting the program if I am taking other medications. (Please initial) _____

10.Certain medical conditions may be worsened if on this program, including glaucoma, hypertension, and heart disease. (Please initial) _____

11.Pregnancy (Females Only). If you become pregnant, inform your physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss. (Please initial) _____

12.The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 27 or higher with other medical conditions such as high blood pressure, diabetes, or high cholesterol. Prescribing medications for patients not fitting these criteria, is considered "off label" and not "FDA approved." Therefore, the potential risks vs. benefits may be great. For patients not fitting the BMI criteria for use of appetite suppression medication, you are acknowledging that:

a. You have put forth a true effort to lose weight through diet and exercise over the past 6 months and have still not achieved your weight loss goals.
b. That your inability to lose weight is causing significant emotional distress
c. You are choosing to enter this medically managed weight loss program voluntary and hold harmless WPPC for use of such medications.
d. (Please initial) _____

13.You acknowledge that alcohol and illicit drug use is prohibited in the program. Drugs like cocaine and amphetamines when used in conjunction with appetite suppressants and other medications prescribed could cause in serious injury or death. The use of alcohol will also affect your results. (Please initial) _____

14.I understand that the physician and I will determine what my daily caloric intake will be at my initial visit. (Please initial) _____

15.I acknowledge that I understand that the amount of weight loss varies from patient to patient, and is, to a large extent dependent on each patient's personal motivation and commitment to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed or implied. I understand the importance of routinely following up with WPPCto monitor my progress during treatment. I understand this is vital to the safety of the treatment program and certify that I will be returning monthly as prescribed. (Please initial) _____

16.I hereby authorize WPPC all Provider's and additional staff of WPPC to evaluate me for admission into WPPC weight management program and treat me accordingly. I consent to obtaining blood work before treatment if deemed necessary. I certify that I am signing this under my free will and am competent to make my own medical decisions. (Please initial) _____

17.I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with medically managed weight loss therapy with WPPC I release any claim in court or any type of complaint that could result from treatment with (LLC NAME), (PROVIDER NAME) and any other staff associated with WPPC and will not hold liable any provider or staff of WPPC. (Please initial) _____

18.I understand that treatment modalities utilized by WPPC might not be supported by scientific/medical literature and could be seen as experimental or based off anecdotal claims. Many medical providers, including endocrinologists, surgeons, family practice doctors, etc., might see these types of treatments as not medically necessary. I also understand that many of the medications being utilized within WPPC and Provider's medically managed weight loss program are considered to be used "off label" and might not be FDA approved for weight loss purposes. (Please initial) _____

WPPC

By signing below, I acknowledge that I have had an opportunity any concerns and the above information with WPPC either in person or by telephone conversation. I consent to the treatment being offered to me by WPPC and I am satisfied with the explanation. I acknowledge that I have read or have had read to me the above consent and understand the information presented.

Printed Name of patient:_____

Signature of patient: _____ Date:_____

Risks and Benefits Acknowledgement

I recognize the potential risks of this treatment program, and I also understand the potential benefits of weight loss, which may include:

1. Decreased risk of heart attack.
2. Decreased risk of adult onset diabetes mellitus.
3. Decrease risk to developing arthritis or developing musculoskeletal conditions that are caused by excessive weight.
4. Increased emotional and psychological well-being.
5. Decreased risk of developing certain types of cancer.

I acknowledge that the medically managed weight loss program recommended to me by WPPC is just one of multiple strategies to reduce weight. Alternative treatment options include:

1. Diet and exercise alone without medications.
2. The use of other kinds of medications to achieve appetite suppression.
3. Non-medical weight loss programs like Weight Watchers.
4. Bariatric Surgery.

_____

Signature of patient Date

_____

Printed Name of patient

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at (LLC NAME) for medically managed weight loss services WPPC offers. I acknowledge I am not wanting to establish primary care with WPPC and I am here for specialized care including weight loss therapy, diet counseling, exercising counseling, (additional services you have) etc.

Print: _____

Signature: _____

Date: _____

Regaining Weight Acknowledgement:

There is a Risk of Regaining the Weight you have lost... Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it back over time. Factors which favor maintaining weight loss include exercise, adherence to a calorie that is low-calorie, nutritious, and full of lean proteins and vegetables, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Utilizing medications to assist you in your weight loss goals in addition to diet and exercise could result in the weight coming back if you do not maintain eating a healthy diet and exercising. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose.

_____

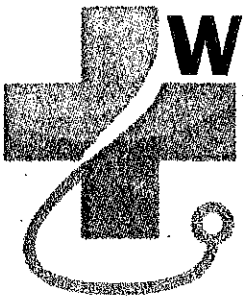
Signature of patient Date

_____

Printed Name of patient

Dr. H. Bui, M.D.

Dr. E. Kanaan, M.D.
Richard Cain, N.P.



WEST PARK
Primary Care
936-328-5820 • 936-328-5824

Lipo-B12 Injections Patient Consent Form

Patient Name: _____

Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take Lipo-B12.

All medications and supplements have potential side effects, including Lipo-B12. Most people tolerate B12 without issue, side effects are rare. Potential common B12 side effects include but are not limited to: mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

You acknowledge:

1. That if I begin to have side effects, I will contact West Park Primary Care immediately and notify them of what is happening @ 936-328-5820.

2. I understand that although rare, Lipo-B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects include: rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.

3. Before starting vitamin Lipo-B12 injections I agree to make my primary care provider aware if I have any of these conditions: Leber's Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that has an effect on bone marrow, or drug/supplement allergies.

4. I understand that there could be interactions with Lipo-B12 and certain medications/supplements.

5. The use of Lipo-B12 on a weekly to biweekly basis without a documented Lipo-B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.

6. Caution is advised while taking Lipo-B12 if you have a sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for Lipo-B12 injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release West Park priamry Care and the person injecting the Lipo-B12 of any damages or liability if anything was to occur.

Patient Signature_____ Date: _____