Aesthetic Essentials Patient Informed Consent for Medical Weight Loss with the use of Phentermine

I hereby authorize Dr. Diethra D. Cox and staff to assist me in my weight reduction efforts. I understand that my treatment program consists of a balanced diet, a regular exercise program, instruction in behavior modifications techniques, and the use of appetite suppressant medication Phentermine. I also understand that regular medical visits will be necessary while on the medication and that Phentermine must be used with caution under direct supervision of Dr. Diethra D Cox and Aesthetic Essentials staff.

**Risk of Proposed Treatment**: I understand that any medical treatment may involve risks as well as the proposed benefits of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risks. Risks of phentermine include but are not limited to **nervousness, diarrhea, constipation, sleeplessness, headache, tremor, fever, fainting, dry mouth, rash, change in libido, difficulty urinating, shortness of breath, swelling of feet/ankles, tiredness, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, hallucinations, stomach cramps, high blood pressure, palpitations, arrythmias, rapid heart rate, and gall stones. Although only seen in rare cases, pulmonary hypertension, or heart valve disease may develop. These latter two conditions are serious and can be fatal. In case of serious side effects, stop taking the Phentermine and seek immediate medical assistance. In addition, Phentermine can be addictive and should not be used with a history of drug dependence.** I also understand that there are certain health risks associated with remaining overweight or obese including high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, sleep apnea, and sudden death.

I further understand that Phentermine should not be used by people who suffer from heart disease, glaucoma, history of a stroke, liver, or kidney disease, those with a history of drug dependence, alcoholism, psychotic illness, uncontrolled hypertension, advanced atherosclerosis, thyroid over-activity, people who are on MAOIs, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medications: Decongestant medications (Sudafed/Tylenol Sinus/Claritin-D/Zyrtec/Allegra), stimulant medications, high doses of caffeine, other weight loss medications, ephedrine MAO inhibitions and alcohol.

**Patient Responsibility**: As the patient, I understand it is my responsibility to follow instructions carefully, and report to Dr. Cox any significant medical problems that I think may be related to my weight control program as soon as possible. I further acknowledge that I enter this program in full knowledge and understanding that no physician, nurse, or staff of the weight loss clinic has prior knowledge as to whether I would or would not have adverse effects since everyone has different biological and chemical make-up. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive Phentermine will be dependent on my progress in weight reduction and weight maintenance.

I am also in full understanding that Phentermine will be used no longer than 3 consecutive months.

Phentermine may result in lethargy or depression with abrupt discontinuation, and I understand that during the program, medications will be discontinued if:

1. I become pregnant, try to become pregnant, or suspect that I am pregnant.
2. I develop a contraindication or serious side effect of the medication.
3. I do not comply with the medical requirements, i.e., visits, med doses, etc.
4. If I fail to lose and/or maintain weight appropriately.
5. I have a planned surgery. Medications are to be stopped at least 2 weeks prior to any surgical procedure requiring general anesthesia.

**Women Only:** I understand that Phentermine should not be taken during pregnancy, due to the chance of damage to the fetus. Phentermine is not to be used while breast feeding.

**NO GUARATNEE: I UNDERSTAND THAT MUCH OF THE SUCCESS OF THE PROGRAM WILL DEPEND ON MY EFFORT, AND THAT THERE IS NO GUARANTEE THAT THE PROGRAM WILL BE SUCCESSFUL. I UNDERSTAND THAT I WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL MY LIFE, IF I AM TO BE SUCCESSFUL LONG-TERM.**

**Patient Consent/Waiver**: I have read and fully understand this document and authorize and accept the proposed care regardless of risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release Dr. Diethra Cox and Aesthetic Essentials from any liability associated and connected with my participation in this weight loss program. I accept the risks listed above, in hopes of obtaining desired beneficial results of weight loss treatment.

Patient Name Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_