Advanced Wellness Augusta
Patient Informed Consent for Dietary Program

I. Program and Alternatives

1. I, _____ *(patient or patient's guardian)* hereby authorize Dr. Paul M. Thaxton, M.D., F.A.C.O.G., A.B.O.M. and his other medical providers or staff to counsel and assist me in my weight reduction and/or maintenance efforts. I understand my treatment will involve a dietary program in combination with exercise as appropriate. My treatment may also include medication(s) depending on if desired by me and if appropriate for me.

2. I understand it is my responsibility to follow the instructions and to report to my medical provider treating me for weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. If I experience a severe or an acute issue, I am to seek immediate care via urgent care or the emergency room and follow-up with my primary care or specialist, as well as to notify this office.

3. I understand that medications and supplements are NOT required to participate in this program. Although medications and supplements can be helpful, it may be possible to achieve my desired results without them.

4. I understand that there are several medications and/or supplement options on the market as well as other program types that can assist me in my desire to decrease my body weight and to maintain the weight loss. In particular, a balanced calorie diet or other exchange eating programs.

5. I understand that if appropriate, my receiving any medication will be depend on my adherence to the program, progress, maintenance, and health status.

6. I understand the purpose of this program is to assist me in my desire to decrease my body weight and / or change my body composition, as well as to maintain my progress.

7. I understand that if desired and appropriate, prescribed / administered medications may be recommended and utilized on or off label in relation to diagnosis, dosing, frequency, etc. Medication options may include compounded medications, which are not FDA approved, even if they are compounded by a compounding pharmacy. Some medications / ingredients may be in clinical trials or otherwise unapproved for specific use.

8. If desired and appropriate, medications and supplements are to be used as adjunct therapy in addition to dietary / lifestyle changes, as well as strength and cardio exercise as medically appropriate for me. I understand that, if necessary, it is my responsibility to get clearance for exercise from my primary care or specialist. I also understand that it is important to maintain muscle mass during the weight loss and maintenance process through exercise and nutrition.

9. I understand that it is recommended that I continue to see my primary care provider at least annually and any specialist as necessary. I am to have annual lab work with my primary care provider as recommended. I am also to inform my primary care provider and specialists of my participation in this weight program and any related medications and / or supplements. GLP-1 medications should be stopped 7-14 days prior to surgeries / sedation.

10. I understand that I can be dismissed from this program /office if it is deemed in my best interest medically or otherwise. I may also be dismissed if I am abusive to staff in any way or if I no-show more than three appointments with less than 24 hours' notice.

11. I understand that I am not to participate in this program to lose weight or take any weight reduction medications or supplements if pregnant or trying to become pregnant. It is my responsibility to know my pregnancy status and to not start or to discontinue any of the above

mentioned in these instances. The statement regarding medication(s) also applies to breastfeeding. It is recommended that medications be stopped at least 3 months prior to becoming pregnant. If I become pregnant, I am to inform this office as well as see an OBGYN.

II. Risks of Proposed Treatment (program and/or medications)

I understand this authorization is given with the knowledge that any program that alters diet may have potential for adverse events and/or side effects. I also understand that all medications and supplements have contraindications, potential for adverse events, side effects, and interactions, some of which may not be known or listed in literature or on consents. I understand that it is my responsibility to read materials provided and to also research any medications or supplements to ensure I understand the potentials. I may also discuss any concerns with my primary care provider and/or specialist, or to obtain medical clearance, if necessary, prior to beginning this program and or medication(s), etc.

III. Risks Associated with Being Overweight or Obese

I am aware that there are certain risks associated with remaining overweight or obese. Risks include but are not limited to high blood pressure, diabetes, heart attack, heart disease, arthritis of the joints, hips, knees, and feet. I understand that in general, a higher BMI or Percentage of Body Fat can increase risks for many health conditions.

IV. No Guarantees

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful, with or without medication(s) or supplement(s). I also understand that I will have to continue managing my weight all of my life if I am to be successful long-term.

V. Patient's Consent

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all of the time I need in reading and understanding this form and in talking with my medical provider regarding risks associated with the proposed treatment and regarding other treatments not involving appetite suppressants.

VI. Insurance

I understand this program (including but not limited to visits, some medications, injections, analysis, etc.) is self-pay and will <u>not</u> be filed to my insurance, even if I potentially have coverage. If labs are deemed necessary, it is my responsibility to determine if they will be covered by my insurance. I am responsible for all costs out-of-pocket; payment is expected in full at time of service. It is my responsibility to review and understand the costs prior to my initial visit.

IMPORTANT

If you have any questions as to the potential risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed program or treatments, or alternatives, ask your medical provider NOW, PRIOR to signing this form. All aspects of this program including services, supplements, and/or medication(s) are non-refundable.

Date: _____ _____ _____

Patient Name PRINTED Patient SIGNATURE

_____ _____

Guardian (if applicable) Medical Provider Signature