SURE SUCCESS MEDICAL WEIGHT LOSS CENTER
PHENTERMINE WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. 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 Dr. THOMAS. I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. Dr._____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 Dr. THOMAS can only prescribe Phentermine and 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 history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. 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:_____

Contraindications and Warnings –

Patients with the following should not use Phentermine:

- An allergy to Phentermine
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or glaucoma
- Are in an agitated state or have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant

Patients with the following should take special precautions and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or high cholesterol or lipid levels

Side Effects –

While Phentermine is generally free of negative side effects, there is the possibility of the following:

- Dry mouth
- Unpleasant taste
- Heartburn
- Skin Rash or Itching
- Diarrhea
- Constipation
- Stomach Pain
- Lactic acidosis
- Nausea/ Vomiting
- Fatigue
- Hypertension
- Insomnia or Restlessness

Less common side effects include:

- Convulsions (Seizures)
- Panic attacks
- Tremors or shaking
- Erectile Dysfunction
- Fever
- Fainting
- Depression
- Hallucinations
- Overactive reflexes

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

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. THOMAS 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. THOMAS at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. THOMAS 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:_____