Consent for Weight Loss Treatment

This agreement between _____ (patient) and Forever Young Health and Wellness establishes guidelines and conditions required to assist me in my weight reduction efforts. The Clinic and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution. Common risks of abusing of appetite suppressants include: nervousness, sleepiness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

The patient accepts and agrees to the following conditions:

1. I understand that the medications I have purchased are prescribed & administered for me based on diagnosis derived from my submitted medical history and physical examination. I understand treatment with the use of Phentermine will not exceed 12 weeks.
2. I understand it is my responsibility to follow the instructions carefully and to report to Vitality medical staff any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
3. I will safeguard my medications from loss or theft.
4. I will not share, sell or trade my medications for money, goods, or services.
5. I agree that I will use my medication at the prescribed rate and dosage, and will keep the medications in its respective labeled container.
6. I will not attempt to obtain appetite suppressants/weight loss medications illegally or from any other health care practitioner without disclosing my current medication usage. **I understand that it is against the law to do so**. I understand I may be discharged as a patient of Forever Young Health & Wellness if other supplementation use is discovered.
7. The risk & the benefit of the use of Phentermine have been fully explained to me & I assume those risks.

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 questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment. My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, severe manic-depressive illness, or history of any eating disorder, since these conditions are contradictory to the use of appetite suppressants. I agree not to take any other suppressants, medications, or injections other than those listed on my medical history form. I agree to inform Forever Young Health & Wellness of any changes in my medications.

Patient Signature:_____ Date:_____