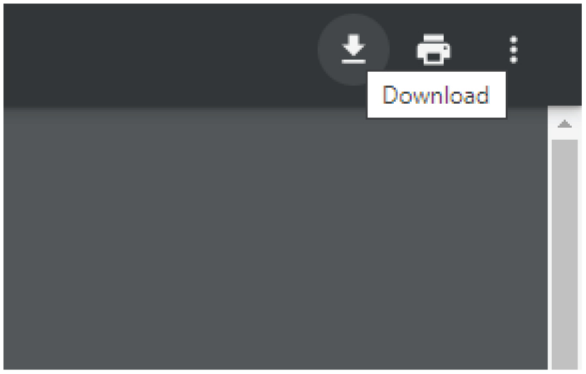
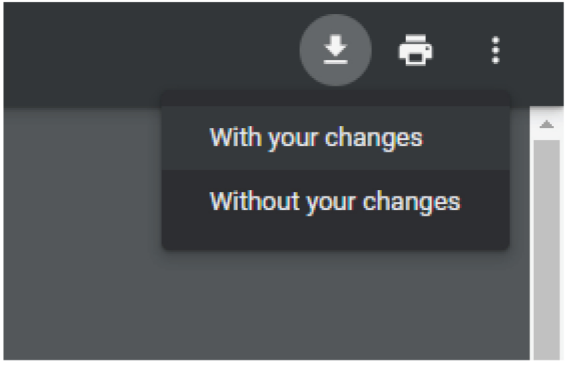
# INSTRUCTIONS TO SUBMIT PAPERWORK:

**Step 1:** Fill in your information in all required fields.

**Step 2:** When completed, click on 'Download' in the top right-hand corner.




**Step 3:** Choose the option for "With your changes". Save the file with your first and last name in the file name.




**Step 4:** Attach the document in an email to **joneschiroclinic@gmail.com**

**Informed Consent for Medically Management Weight Loss Therapy**

I acknowledge that I am voluntarily entering into a medically managed weight loss program with Total Health and Wellness**.** 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 Total Health and Wellness/ Whitney Matchette 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

13. I understand that the medication I am receiving is a compounded medication that also includes the supplement L- carnitine. (please initial) _____

    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 voluntarily and hold harmless Total Health and Wellness for use of such medications. (Please initial) _____

14. 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) _____

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

16. 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 Total Health and Wellness to 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) _____

17. I hereby authorize Total Health and Wellness, Whitney Matchette, NP and additional staff of Total Health and Wellness to evaluate me for admission into Total Health and Wellness 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) _____

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

19. I understand that treatment modalities utilized by Total Health and Wellness 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 Total Health and Wellness medically managed weight loss program are considered to be used "off label" and might not be FDA approved for weight loss purposes.
    (Please initial) _____

By signing below, I acknowledge that I have had an opportunity to voice any concerns and the above information with Total Health and Wellness, either in person or by telephone conversation. I consent to the treatment being offered to me by Total Health and Wellness 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.

_____

Signature of patient Date

_____

Printed Name of Patient

**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 Total Health And Wellness 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 Total Health and Wellness for medically managed weight loss services Total Health and Wellness offers. I acknowledge I am not wanting to establish primary care with Total Health and Wellness, and I am here for specialized care including weight loss therapy, diet counseling, exercising counseling, 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

**Patient History Form for GLP-1 Weight Loss Peptides**

Total Health and Wellness
801 E Watauga Ave #2
Johnson City, TN 37601
(423)773-0300

Patient Name: _____DOB: _____Date: _____

Address:_____

Phone:_____ Email:_____

**Medical History**

- [_] Overweight
- [_] Difficulty losing weight
- [_] Diabetes (Type 1 or Type 2)
- [_] Insulin Resistance
- [_] Hypoglycemic
- [ ] PCOS
- [_] Infertility
- [_] Autoimmune disease
- [_] Heart Attack/Heart Problems
- [_] Stroke
- [ ] GERD/Heartburn
- [ ] Addictions; Smoking/Alcohol/Drugs
- [_] Cravings/Food Binging
- [ ] Gastroparesis
- [ ] Pancreatitis
- [ ] Gallbladder Disease
- [_] IBS (Irritable Bowel Syndrome)
- [ ] Kidney Disease
- [ ] Liver Disease/Fatty Liver
- [ ] Low Testosterone
- [ ] Depression/Anxiety/Moodiness
- [ ] High Blood Pressure/High Triglycerides
- [ ] High Cholesterol
- [ ] Obstructive Sleep Apnea
- [ ] Joint pain/Arthritis
- [_] Chronic Inflammation
- [_] Parkinsons
- [_] Medullary Thyroid Disease/Cancer *
- [_] Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) *
- [_] Pregnancy/Breast Feeding *
- [_] Diabetic Retinopathy *
- [ ] Other: _____

**Current Mediciations:**_____

_____

_____

**Allergies:**_____

**Family History**

- [_] Obesity
- [_] Diabetes (Type 1 or Type 2)
- [_] Medullary Thyroid disease/cancer
- [_] Heart Attack/Heart Disease
- [_] Liver Disease/Fatty Liver
- [_] Kidney Disease
- [_] High Blood Pressure
- [_] High Cholesterol
- [_] Stroke
- [_] Cancer: colon; liver; breast; skin; endometrial; pancreatic; other:_____
- [_] Alcoholism/Smoking/Drug Addiction
- [_] Depression/Anxiety
- [_] Dementia/Alzheimers
- [_] Parkinsons

**Primary Care Physician:**

Name:_____Phone:_____

**Previous Weight Loss Treatments**

- [ ] GLP-1 meds (Ozempic, Wegovy, Mounjaro, Zepbound, etc.)
- [ ] Phentermine
- [ ] Topiramate
- [ ] Bariatric Surgery
- [ ] HCG
- [ ] Over-the-counter supplements
- [ ] Supervised Medical Programs
- [ ] Exercise Programs

**Notes:**

**Patient Signature:**_____**Date:**_____

**Provider Signature:**_____**Date:**_____

# Total Health and Wellness

801 E Watauga Ave #2
Johnson City, TN 37601
Phone: 423-773-0300

## Telehealth Appointment Fee Acknowledgement

I understand that the fee for a Telehealth appointment is **$50.00**.

I also understand that this fee is non-refundable, regardless of whether treatment is initiated or continued.

Furthermore, I acknowledge that the Telehealth fee is non-refundable if the appointment is canceled or missed by the patient for any reason.

By signing below, I acknowledge and agree to this policy.

Patient Name: _____

Patient Signature: _____ Date: _____