Premier Physicians
Weight Loss & Wellness

PATIENT INFORMED CONSENT

Please Initial The Following Paragraphs:

_____**I give authorization:** I hereby authorize Dr. Dana Trippi, Dr. Erik Evensen and all associates, whether they be employees or contractors, that are currently licensed providers within Premier Physicians practice to assist me in my weight reduction efforts. I understand my treatment may involve, but is not limited to the use of appetite suppressants for more than 12 weeks and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling. I understand that the medication will only be prescribed when the expected benefits are felt to be greater than the risks. I also understand that regular medical visits will be necessary while on the medications and that these medications must be used with caution and under direct supervision of the provider.

_____**Nevada Law AB 474:** Prior to giving me a Controlled Substance prescription my provider is required by AB 474 to obtain my written Informed Consent. My provider has explained to me that these medications may include drugs that can be used for appetite suppression and weight loss as well as other indications such as depression, anxiety, and migraines. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

1) Restlessness
2) Nervousness
3) Headache
4) Constipation
5) Dry Mouth
6) Insomnia
7) Increased pulse
8) Increased Blood Pressure

_____**I have read and understand the following physician statement:** "Medications including the appetite suppressants have labeling that has been agreed upon by the maker of the medication and the Food and Drug Administration. This labeling contains, among other things suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosage indicated in the labeling. As a medical provider, I have found the appetite suppressant helpful occasionally for periods more than 12 weeks and at times in larger doses than suggested by the labeling. As a providers, we are **NOT** required to use medications as the labeling suggests, but we are required to use labeling as a source of information, along with our own clinical experience, the experience of our colleagues, recent longer-term studies, and recommendations of university based investigators. Based on this, we may choose when indicated to use the appetite suppressants for longer periods of time, and at times, in increased doses, albeit very rarely. Such usage has not been as systematically studied as the usage suggested in the labeling, and it is possible, as with most other medications that there could be serious side effects as noted below. As providers, we need to weigh the risks and benefits of the appetite suppressant use with the risk of remaining overweight."

_____**Risk of proposed treatment:** I understand this authorization is given with the knowledge that the use of appetite suppressants involves some risk and some hazards. Most appetite suppressants should be used with extreme caution by people who suffer from glaucoma, alcoholism, psychotic illnesses, uncontrolled high blood pressure, advanced arteriosclerosis, thyroid over activity, people who are on certain other medications, i.e. monoamine oxidase inhibitors (MAOIs), certain serotonin type migraine medications, antimanic agents (lithium), some over the counter decongestants, and any other over the counter or prescription form anorectic agents. The more common side effects of appetite suppressants include, but are not limited to nervousness, diarrhea or

constipation, sleeplessness, headache, dry mouth, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, high blood pressure, palpitations and heartbeat irregularities, and gallstones. Although only seen in rare cases, pulmonary hypertension or heart valve disease may develop. These conditions are serious and can be fatal. More studies are currently being done to document this further. I am willing to undergo studies as indicated by my weight loss physician if necessary for the purpose of ruling out underlying disease that may be a contraindication to the use of appetite suppressant.

_____**Patient responsibility:** As the patient, I understand it is my responsibility to follow instructions carefully and to report to the doctor treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I agree to notify my weight loss provider of any medical problems, illnesses or changes to current over the counter or prescribed medications that I may have had, that they are not aware of, or any results of labs/tests, ordered and reviewed by any other treating physicians. I further acknowledge that I enter into this program in full knowledge and understanding that no physician, provider or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effects due to the fact that each individual has a 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 the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that a balanced calorie counting program without the use of appetite suppressants may likely prove successful if followed, even though I would be hungrier than without the suppressant. I also understand that there are also risks of remaining overweight or obese. I understand that abrupt discontinuation of the appetite suppressant may result in lethargy or depression.

_____ I understand that during the program, medications will be discontinued or I may be discontinued as an existing patient of Premier Physicians if:

1) I become pregnant, try to become pregnant, or suspect I am pregnant
2) I develop a contraindication or serious side effect of the medication
3) I do not comply with medical requirements of, including but not limited to, advised regular consistent office visits, or prescribed medication doses, etc.
4) I fail to lose and/or maintain weight appropriately
5) I use another medication that is not compatible
6) I have a planned surgery (medications are to be stopped at least 2 weeks prior to a procedure).
7) I fail to advise all physician and health care associates of all my current medication lists, or fail to advise all physicians of controlled substances being prescribed to me or have accepted and filled multiple prescriptions of same or like controlled substances from multiple treating physicians.
8) It is deemed that the patient-provider relationship is not in the best interest of the patient, or patient has exercised and/or exhibited unprofessional, abusive or aggressive behavior.

_____**Off Label Medications:** I understand that occasionally other medications such as antidepressants, diabetic medications, diuretics, and anti-seizure medications are used for the purpose of aiding weight loss. I understand that these are considered off label use for weight loss, but can at times be of significant benefit. I understand that all medications carry a risk of side effects and that I need to weight the risk and benefits of all medications before use.

_____**I have an opportunity to ask, and have questions answered fully.** I have been given an opportunity to ask questions. The risks, benefits, and alternative treatments, including their risks and benefits have been explained to me. I understand that not every possible risk and benefits is listed on this form and that this consent

includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death. All my questions have been answered fully.

_____**Danger of controlled substances to my children.** I have been informed of the risks that my child may abuse, misuse or divert these controlled substance medications and ways to detect such misuse. I have discussed with my prescriber the methods to safely store and legally dispose of the controlled substance. I understand that prescriptions should always be stored in a secure place and out of the reach of children and other family member(s). To safely dispose of unused medications, I can return my medications in the bottle to a local pharmacy, a local drug-take back day, a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Detera bag, which maybe be available for purchase at my pharmacy.

_____**No guarantee:** 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.

_____**Labs/EKG:** I understand that it is my sole responsibility to follow up on pending labs and/or EKG results if I choose not to continue with this weight loss program prior to evaluation and interpretation of the labs and/or EKG results. I understand that any pending labs and/or EKG may reflect abnormalities which would need follow through with a primary care physician. I understand it is my responsibility to give Premier Physicians the name of a primary care physician where labs and/or EKG can be sent for follow through and interpretation.

_____ **Pregnancy waiver:** By initialing this paragraph I certify that I am not currently pregnant, I do not suspect that I may be pregnant, and I am currently not trying to become pregnant. Should I become pregnant during my participation in the weight loss program it is my sole responsibility to; 1) immediately inform Premier Physicians, 2) discontinue any medications and/or calorie restrictive diet plans that have been prescribed for me by Premier Physicians, and 3) discharge myself from the program until after the term of my pregnancy.

_____**Patient consent/waiver:** The goal of this treatment is for the management of my current medical condition. I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications. 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 authorize and direct my provider to prescribe controlled substances(s). I understand in order to initiate or continue treatment with controlled substance I must agree to the conditions set forth above. I hereby release all providers and any and all employees from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.

_____**Media waiver:** By signing below, Patient does hereby grant Premier Physicians consent to use Patient's testimonial, likeness, or any other materials provided to, or developed by, Premier Physicians by and with Patient during the course of engagement in the program, for media related uses.

Financial Policy:

_____**Cash Pay Patients**: Please be advised that the non-refundable payment of $50 will be due at time of scheduling of an appointment for the initial assessment and will be applied toward the initial consultation fee of

$199. (Includes: EKG, labs and initial provider consultation). If you cancel or reschedule without providing us 48-hours notice your deposit will be forfeited and an additional $50 deposit will be required to schedule a new appointment. On day of initial visit the remaining balance of the $199 will be due upon arrival and prior to provider consultation, EKG and lab draw. Follow up visits are $99, medications and injections are additional, and all pricing is subject to change at the sole discretion of Premier Physicians Weight Loss and Wellness. You are financially responsible for all charges for office visits and/or medications during the course of your engagement in the program. A current credit card will be required to be maintained on file with our office for payment of services or medications not covered by insurance. All Charges are due at time of service.

_____**Insured patients/Contracted patients:** If you have a **copay**, it is due upon arrival for your visit. If you no longer meet criteria for weight loss management based on your employer's contract, and should you choose to continue with weight loss management, you will automatically become a cash pay patient with same charges applicable as any other cash pay patient within this practice. You are solely responsible for alerting PPW of any changes or additions to your insurance coverage(s). Should your insurance deny payment for any reason, you are financially responsible for any and all costs of services and/or medications provided or prescribed by Premier Physicians. In the event that you do not pay for charges denied by your insurance for any reason, our billing department reserves the right to implement the collection policies in place at that time to recover any amount due.

Copies of Medical Records are $0.60 per page. Whether a cash-pay patient or insured/contracted patient a $50 fee will apply to "no shows" or rescheduled appointments without a 48-hour notice and your credit/debit card on file will be charged. For your convenience we accept cash, debit cards, most major credit cards and CareCredit. We do not accept ***personal checks.***

I have read and understand all of the above and agree to these statements.

Patient: _____ **Date:** _____
PRINT NAME and Sign

Witness: _____ **Date:** _____
PRINT NAME and Sign

Provider Declaration: I certify that I have explained the contents of this document to the patient and have answered all the patient's related questions fully. To the best of my knowledge, I believe the patient has been adequately informed concerning the benefits and risks associated with the use of controlled substances, appetite suppressants, the benefits and risks associated with alternative therapies, and the risks concerning an overweight status. After being adequately informed, the patient understands what I have explained and has consented to treatment.

Provider signature: _____ Date: _____

Topiramate/ Topamax/ Trokendi-XR/Qsymia Consent

The Risk of Birth Defects with Topiramate™

Please read the following important safety information about the use of Topiramate in females who can become pregnant.

You are considered a female who can become pregnant if this applies to you:

- You have never had a hysterectomy (uterus removed), surgical sterilization (tubes tied), or both ovaries removed and
- You have not gone through menopause. Menopause should be confirmed by your healthcare provider.

1. **Topiramate can increase the risk of a birth defect called cleft lip or cleft palate**
    - These defects happen early in pregnancy, sometimes even before you know you are pregnant

2. **You should have a pregnancy test taken BEFORE starting treatment with Topiramate and EVERY MONTH after that while on treatment**
    - Talk with your healthcare provider about when and where to have your pregnancy testing performed
    - If you have a positive pregnancy test, or miss a period, or think you might be pregnant, you must not start Topiramate, or if you are already taking Topiramate, you should stop it immediately and tell your healthcare provider right away

3. **While you are on Topiramate therapy, you should use effective birth control methods every time you have sex with a male**

Certain birth control methods are effective when used alone. Other birth control methods are not as effective by themselves, so you should use a second method of birth control

4. **While on Topiramate be aware of the following:**

- **Metabolic Acidosis-periodic measurement of serum bicarbonate level required**
- **Report any visual changes**
- **Report any decrease in sweating, or increased temperature**
- **Drink plenty of water with this medication to prevent renal stones**

- **Report any suicidal behavior or ideation**
- **Do not stop this medication without calling us**

Talk to your provider to help you decide what birth control options are best for you.

Your Birth Control Options

<table>
<tr><th colspan="2">OPTION 1 – Highly Effective Methods to Use Alone</th></tr>
<tr><td colspan="2">

- Intrauterine device (IUD) or intrauterine system (IUS)
  - Copper IUD
  - Levonorgestrel-releasing IUS
- Progestin implant
- Tubal sterilization
- Male partner's vasectomy

</td></tr>
<tr><th colspan="2">Option 2 – Acceptable Methods to Use Together</th></tr>
<tr><th>Choose first method</th><th>Choose second method</th></tr>
<tr><td>

Hormonal Contraception

- Estrogen and progestin
  - Oral (the Pill)
  - Transdermal patch
  - Vaginal ring
- Progestin Only
  - Oral
  - Injection

</td><td>

Barrier Method

- Diaphragm (with spermicide)
- Cervical cap (with spermicide)
- Male condom (with or without spermicide)

</td></tr>
<tr><th colspan="2">Option 3 – acceptable Methods to Use Together</th></tr>
<tr><th>Choose first method</th><th>Choose second method</th></tr>
<tr><td>

Barrier Method

- Diaphragm (with spermicide)
- Cervical Cap (with spermicide)

</td><td>

Barrier Method

- Male condom (with or without spermicide)

</td></tr>
</table>

Keep in mind, even the most effective birth control methods can fail. But your chances of getting pregnant are lowest if the methods you choose are always used correctly and every time you have sex.

I _____ understand that I must take an at home pregnancy test BEFORE starting any medication containing **Topiramate** and then once a month while on the **Topiramate** containing medication. If pregnancy test is positive, period missed, or I think I might be pregnant, I must not start any **Topiramate** containing medication, or if already taking any **Topiramate** containing medication I must stop it immediately and tell my health care provider right away.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physicians Signature: _____ Date: _____