



Weight Loss Consent for Medications and Treatment

I request the use of Phentermine or other appetite suppressants, 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. Kongsiri. I understand there is no guarantee for the effectiveness of Phentermine or other appetite suppressants and I have received a copy of the weight loss handbook that clearly outlines the side effects and dosage. I agree that I am and will be under the care of another medical provider for all other conditions. Dr. Kongsiri 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. Kongsiri can only prescribe Phentermine and other 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, certain foods, or other substance.

Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days

Have advanced arteriosclerosis, cardiovascular disease, 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



I understand Phentermine and suppressants 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. Kongsiri 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. Kongsiri 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. Kongsiri at that time.

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: _____ Date: _____

Patient's Name Signed: _____

Provider's Name Signed: _____ Date: _____