MOBILE BAY MEDICAL WEIGHT LOSS
ALABAMA STATE LAWS

1. I have made a substantial good-faith effort to lose weight by utilizing a regimen of weight reduction based on diet modification, behavioral modification and exercise without utilizing controlled substances and that said treatment has been ineffective.
   Int: _____ Date: _____

2. I understand the medication does not guarantee weight loss. I understand that I can lose weight simply by restricting my calorie intake and enhancing weight loss by implementing an exercise program.
   Int: _____ Date: _____

3. I understand the weight loss medication(s) are not only appetite suppressants, but are also stimulants and can increase my heart rate and raise my blood pressure. Other common side effects have also been identified (sleeplessness, dry mouth, constipation, etc.)
   Int: _____ Date: _____

4. By Alabama State Law, I understand if I fail to lose weight under treatment with a prescribed weight loss stimulant over a thirty (30) day period (which determination shall be made by being weighed at least every thirty (30) days), I will not be allowed to continue a weight loss regimen that includes utilizing a stimulant who fails to lose weight during his/her first month. They will be allowed an additional 30 days, to utilize a different stimulant.
   Int: _____ Date: _____

5. By Alabama State Law, I understand I will not be allowed to continue taking a weight loss stimulant if it is determined I have developed a tolerance (a decreasing contribution of the drug toward further weight loss) to the medication.
   Int: _____ Date: _____

6. By Alabama State Law, I understand I am not allowed to take a prescribed weight loss stimulant for more than <u>six (6) thirty (30) day supplies during a (12) twelve-month period of time.</u> I understand a twelve-month time period is considered to begin on the day of the initial dispensation or prescription issuance.
   Int: _____ Date: _____

Medication Information

Alabama State Law requires us to inform you of the purpose and nature of our program, including the risk associated with the medication used for treatments, and obtain your consent for such treatment. Please read over this page and ask any questions you may have. We recommend that you consult with your primary physician regarding this program, and any medications you may be taking. The general nature and purpose is dietary education supplemented with appetite suppressants and other beneficial supplements used in the treatment of weight loss. The medications are used as oral appetite suppressants in conjunction with an overall diet plan to reduce weight.

Some side effects known to be associated with medication are as follows:

1. **ADIPEX 37.5 MG (PHENTERMINE 37.5 MG)**
   TENUATE 75 MG (DIETHYLPROPION)
   IONAMIN 30 MG (PHENTERMINE 30 MG)
   BONTRIL 105 MG (PHENDAMETRAZINE 35 MG)
   Dry mouth, Nervousness, Headache, Insomnia, Palpitations, Impotence, and lack of Libido. Not recommended for individuals with Hypertension, Hyperthyroidism, Glaucoma, Cardiovascular Disease and Advanced Arteriosclerosis.

2. **SEMAGLUTIDE (WEGOVY)**
   Dizziness, Fatigue, Gastrointestinal Issues (diarrhea, constipation and gassiness), Stomach Issues including nausea, vomiting, pain or distension (bloat)**.**

I acknowledge that I have read and have been informed of the nature of this weight loss program and the side effects associated with the medication(s) that may be prescribed to me. I also acknowledge that this consent form shall remain valid until revoked by me in writing. I further affirm that I understand that once the medication is purchased, by law I cannot return it for any reason. I understand that if I request to have the medication destroyed, and in return want to try another medication, I will be charged for the doctor visit, and the medication again as a normal doctor visit.

SIGNATURE: _____ DATE:_____

MOBILE BAY MEDICAL WEIGHT LOSS

THIS IS A RECORD OF YOUR MEDICAL HISTORY AND WILL NOT BE RELEASED FROM THIS OFFICE UNLESS AUTHORIZED BY YOU.

Name: _____ Age: _____ S.S #: _____
Occupation:_____
Driver License #: _____ State Issued : _____
Name of family physician: _____

Please check any of the following chronic illnesses or conditions you currently have or have had in the past :

___ Stroke
___ Alcohol Addiction
___ Heart Disease
___ Depression
___ Seizure Disorder
___ High Blood Pressure
___ Bulimia
___ Anorexia
___ Migraine
___ Diabetes
___ Thyroid Disease
___ Glaucoma
___ Prostate Problems
___ Mitral Valve Prolapse
___ Drug Addiction

Is there a history of the following in your family?

___ Heart Disease
___ High Blood Pressure
___ Diabetes
___ Obesity
___ Stroke

If yes, which relative?_____

Are you currently pregnant?_____

Nursing?_____

Do you currently smoke?_____

Female Patients Only: Diet medication can be potentially harmful to a fetus. It is imperative to use extreme caution with a form of birth control. Please list your current form of birth control: _____

How many meals per day, do you eat? _____

Do you often skip meals?_____

Have you ever taken an appetite suppressant before? _____

If so, which one? _____

Did you lose weight? _____

Please list all allergies or reactions to medication or foods: _____

_____

PLEASE BE SURE TO UNDERSTAND ALL THE DOCTOR'S INSTRUCTIONS BEFORE LEAVING THE OFFICE.

Dear Patient,
Thank you for choosing Mobile Bay Medical Weight Loss for your weight loss needs/ Please feel free to ask our staff any questions you may have about the weight loss program. We want to make it our top priority to make you feel as comfortable as possible. Please understand that we don't claim that an enormous amount of weight will be lost in a short amount of time and we have no hidden gimmicks. The medication we prescribe to you will reduce your appetite, speed up your metabolism, and will also give you energy.

General Vitamin Injection Informed Consent

Patient's Name: _____ Date: _____

Vitamins are vital for our body's normal function and are absolutely necessary for our growth, general well-being, and vitality. Except for a few exceptions, vitamins cannot be manufactured or synthesized by the body, and their absence or improper absorption results in a specific deficiency disease. Proper vitamin injections can supply the much-needed nutrients your body needs to maintain and enhance normal bodily functions.
Vitamin Injections common side effects include but are not limited to:

1. I understand there is a risk of mild diarrhea, upset stomach, nausea, a feeling of pain and warm sensation at the site of the injection, a feeling or sense of being swollen over the entire body, headache and joint pain.

2. If any of these side effects become severe or troublesome you should contact your physician immediately.

3. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescriptions, and nonprescription medications may result in side effects when they interact with Vitamin Injections.

4. I understand that although rare Vitamin Injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking Vitamin Injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of Vitamin Injections, such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects include:

- Constipation, Bloating, Diarrhea, Nausea, Upset Stomach
- Indigestion or Heartburn, Gastrointestinal Hyperactivity
- Chest pain, Rapid Heartbeat
- Chills, Fever, Flushed face, Hypertension (high blood pressure)
- Infection, Kidney stones, Osteoporosis
- Fingernail weakening, Hair loss, Headache, Abnormal Bleeding
- Attention Deficit Hyperactivity Disorder (ADHD)

- Muscular Dystrophy, Hypoglycemia, Benign prostatic Hypertrophy (BPH
- History of seizures, Elliptic seizures, Schizophrenia
- Folic acid deficiency, Iron deficiency
- Diabetes, Mellitus, or High Blood sugar levels
- Allergic reaction to other medicines, food, dyes, or preservatives, Acetaminophen poisoning

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent Vitamin Injection with the above understood, I hereby release the doctor, the person injecting the Vitamin Injection, and the facility from liability associated with this procedure.

Signature: _____ Date: _____

CONSENT TO TELEHEALTH VISIT

Patient Name:_____ Date:_____

1. **Purpose:**
The purpose of this form is to get your consent for a telehealth visit.

2. **How Telehealth Works:**
In a telehealth visit, you will interact in real time with your healthcare provider ("Provider") via the use of secure electronic or telephonic communication. The Dr. will determine upon visit if you meet the criteria to receive prescribed medication.

3. **Medical Record and Privacy:**
All federal and state laws covering access to your medical records (and copies of medical records) also apply to telehealth. All information given at your telehealth visit will be protected by federal and state privacy laws.

4. **Your Rights:**
You may opt-out of the telehealth visits at any time. This will not change your right to future care or health benefits.

5. **Waiver/Release:**
By signing below, you consent to receive services via telehealth and understand and agree the you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit.

Signature of Patient: _____ Date:_____

OFFICE USE ONLY

Name: _____ DOB: _____

Verify Address ____ Verify Phone Number ___ Verify Medication ____

_____

_____

Initial BMI: _____ Height: _____ Goal Weight: _____

Occupation: _____

Date	Weight	BMI	BP	Doctor Comments	Doctor

Mobile Bay Medical Weight Loss

Name:_____ DOB: _____

Address:_____

City:_____ State:_____ Zip: _____

Contact Number: _____ Email: _____

**** CONSENT TO RECEIVE TEXT OR EMAIL APPT REMINDERS****
PLEASE CIRCLE Y OR N

Age:_____ Sex:_____ Goal Weight: _____

Allergies:_____
_____

Current Medications:
_____

_____

FOR OFFICE USE ONLY