

Welcome to our office.

Thank you for choosing our office to help in your weight loss efforts. We are happy to have you. If you have a primary care physician that you would like us to keep apprised of your treatment, let us know. You will notice when you walk in that we have received several awards for achieving high levels of patient satisfaction. Dr. Knopke has on several occasions been awarded as America's Top Doctor. We strive for the best but we learn from you. Should you have any concerns please let us know or call Dr. Knopke directly at 951-774-2721.

Dr. Knopke is a member of the Obesity Medicine Association. The OMA is an organization dedicated to the education of physicians in helping patients to lose weight in a safe and effective manner. Dr. Knopke is an active participant in this organization and has given talks to help other doctors learn to become specialists in Obesity Medicine.

Losing weight is a difficult process. Many of our patients have tried and failed many times in their weight loss efforts. We want to let you know that this is a normal pattern that we see. Our philosophy of weight loss can be summed up in 3 statements:

1. Obesity or the state of being overweight is a chronic disease.
2. Obesity or the state of being overweight is a disease process with a physiological cause, like diabetes or hypertension. It is not a result of "weakness" or "lack of willpower".
3. Obese or overweight individuals have a right to treatment that is safe and effective.

Patient Information

Patient Number: _____

Name:	Date of Birth:
Address:	Social Security #:
Address:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City:	Language:
State: Zip:	Employer:
Home Phone:	Emergency Contact:
Work Phone:	Emergency Phone #:
Cell Phone:	Emergency Relationship:
Primary Care Doctor:	Email:

Guarantor Information (if different from above)

Name:	Date of Birth:
Address:	Social Security #:
Address:	
City:	Employer:
State: Zip:	Emp Address:
Home Phone:	Emp City:
Work Phone:	Emp State: Zip:
Cell Phone:	

Insurance Information

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Primary Address:	Secondary Address:

Photography Advertising Consent

We believe a picture is worth a thousand words. Help others by telling them about your success! We are seeking your permission to use before and after pictures to document your success. We would like to use a photo, taken up to 12 months before starting your weight loss program or taken here at your first visit, at regular intervals throughout the program and upon reaching your weight loss goal. Pictures may be used on our website or other advertisements. We will either use a first name in the ad. We may modify the picture(s) such as cropping, color correction, and red eye correction and we may add comments such as “Anne lost 30 pounds!”

Pictures may also be dropped off at the front desk or may be emailed directly to Dr. Knopke at drknopke@inlandempireweightloss.com.

- Yes, I, _____, give my permission to Inland Empire Weight Loss to use my before, progress, and after weight loss photographs for advertising purposes.
- No, I do not wish to use my photograph(s) for advertising purposes.

Signature: _____ Date: _____

Tell me about yourself

Weight Loss

Heaviest weight: _____

How many diets have you tried?

Ever tried a medically supervised diet?

Weight loss clinic(s) Weight Watchers

Has anything worked? _____

Lightest weight (in adult life): _____

0 1 2 3 Too many to count

Yes No

Jenny Craig Lindora Other: _____

Medications

Previous appetite suppressants?

Phentermine Phen-Fen

Qsymia Saxenda

Diethylpropion Contrave

Belviq

_____ Problems? _____

Diet and Exercise

Do you like to exercise?

Yes No

When you exercise, what do you do?

Walking Jogging

Stationary bike Videos

Other _____

What do you eat? Give 2 examples of each:

Breakfast: _____

Lunch: _____

Dinner: _____

Tell me about snacks and sweets:

Morning Afternoon Bedtime

Daily 3-4 days per week Rarely

What do you snack on? _____

Desserts: _____

Daily 3-4 days per week Rarely What do you eat: _____

What is your biggest contributor to your weight problem? _____

Eating Behaviors

Do you feel that you need to have a snack before bedtime? Yes No

Does having a snack before bedtime help you to sleep? Yes No

What do you usually eat? _____

Do you generally skip breakfast? Yes No

Do you tend to eat large amounts of food? Yes No

Do you feel that you lack control over the amount of food that you eat? Yes No

Do you feel that you eat more rapidly than normal? Yes No

Do you eat until you are uncomfortably full? Yes No

Do you eat large amounts of food when not physically hungry? Yes No

Do you hide your eating because you are embarrassed? Yes No

Do you feel disgusted, depressed, or guilty after eating in the way described? Yes No

Have you ever purged such as intentionally vomited, taken laxatives, or exercised excessively? Yes No

Review of Systems

Have you had any of the following?

Constitutional

Y N Fatigued Y N Weight Loss Y N Weight Gain Y N Always Cold Y N Daytime Sleepiness

Eyes

Y N Eyeglasses Y N Contact Lenses Y N Blurred Vision Y N Visual Changes

Ears Nose Mouth and Throat:

Y N Nasal Discharge Y N Post Nasal Drip Y N Snoring Y N Sleep Apnea

Respiratory:

Y N Tightness Y N Wheezing Y N Cough Y N Short of Breath

Cardiovascular

Y N Chest pain Y N Chest Pressure Y N Palpitations Y N Edema

Gastrointestinal:

Y N Heartburn Y N Constipation Y N Nausea Y N Abdominal Pain

Genitourinary:

Y N Decreased flow Y N Nightly Urination Y N Partial Voiding Y N Urinary Urgency Y N Urinary Frequency
Y N Heavy Menses Y N Irregular Menses Y N Incontinence

Musculoskeletal:

Y N Knee pain Y N Hip Pain Y N Ankle Pain Y N Back Pain

Dermatology

Y N Skin tags Y N Acne Y N Hirsutism Y N Dryness Y N Hair Loss

Neurology

Y N Headache Y N Tingling Y N Numbness Y N Dizziness Y N Seizures

Psychiatric

Y N Depression Y N Anxiety Y N Irritability Y N Addictive
Y N Can't Feel Pleasure Y N Poor Focus Y N Racing Thoughts Y N Carb/Sweet Cravings
Y N Rapid Eating Y N Insomnia Y N Impulsive Behavior Y N Compulsive Behavior

Endocrine

Y N Hypoglycemia Y N Hunger Y N Anorexia

Heme/Lymph:

Y N Bruising Y N Blood Clots Y N Peripheral Edema Y N Swollen Lymph Nodes

Allergic/Immuno

Y N Sneezing Y N Hives Y N Seasonal Allergies Y N Frequent Illnesses

Name: _____ DOB: _____ Date: _____ Sex: M F

Past Medical History

Metabolic problems:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Prediabetes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Low Thyroid |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Peripheral Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Triglycerides |

Sleeping / Breathing problems:

- | | | | | |
|--|--------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Asthma | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Shift Work Sleep Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sleep Eating | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Restless Sleep |

Eating Disorders / Addictions (or history of):

- | | | | | |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Binge Eating | <input type="checkbox"/> Eating At/Before Bedtime | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Nicotine Dependency | <input type="checkbox"/> Work Addiction | <input type="checkbox"/> Addictive Behaviors | <input type="checkbox"/> Other _____ |

Neurological problems:

- | | | | | |
|---|---|--|--|-----------------------------------|
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Headaches (other) | <input type="checkbox"/> Spinal/Foraminal Stenosis | <input type="checkbox"/> Sciatica |
|---|---|--|--|-----------------------------------|

Musculoskeletal Problems:

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Knee Arthritis | <input type="checkbox"/> Hip Arthritis | <input type="checkbox"/> Foot/Ankle Arthritis | <input type="checkbox"/> Spinal Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Degenerative Disk Disease | <input type="checkbox"/> Sacroiliac Joint arthritis | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Plantar Fasciitis |

Gastrointestinal / abdominal problems:

- | | | | | |
|--------------------------------------|------------------------------------|----------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hernias | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Ulcers/Gastritis |
|--------------------------------------|------------------------------------|----------------------------------|--------------------------------------|---|

Skin problems:

- | | | | | |
|------------------------------------|---|--|---|-------------------------------|
| <input type="checkbox"/> Skin Tags | <input type="checkbox"/> Acanthosis Nigricans | <input type="checkbox"/> Stretch Marks | <input type="checkbox"/> Skin Fold Infections | <input type="checkbox"/> Acne |
|------------------------------------|---|--|---|-------------------------------|

Psychosocial problems:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> OCD | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Low Self Esteem |
| <input type="checkbox"/> Body image Dissatisfaction | <input type="checkbox"/> Intimacy Impairment | <input type="checkbox"/> Work Absenteeism | <input type="checkbox"/> Decreased Productivity | <input type="checkbox"/> Social Impairment |

Genitourinary Problems:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Difficulty Getting Pregnant | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Low Testosterone | <input type="checkbox"/> Loss of Strength | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Poor Motivation |

Other: _____

Medications: _____

Medication Allergies: _____

Surgical History: _____

Family and Home

- Family History of:**
- | | | | | |
|--|-------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Parents | <input type="checkbox"/> Siblings | <input type="checkbox"/> Children | <input type="checkbox"/> Grandparents | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart/vascular disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Addictions | |

Details: _____

Home and Work:

- Marital Status: Married Single Divorced Widowed Last / Current Occupation: _____
- Smoking: Current Prior Never Quit Date: _____ Alcohol Yes No Frequency: _____

Assignment of Benefit/Authorization

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the responsibility of the patient to pay any deductible, co-pay, co-insurance, or in cases where the care is not covered by insurance, you will be charged for the entire cost of the non-covered service.

The total charges for office visits will be due at the conclusion of the office visit. If there is a co-pay, this will be due at sign-in. We cannot bill co-pays, deductibles, or cash visit charges to you at a later date.

If this account is assigned to an attorney or collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including MediCare, private insurance, and other health plans to: Raincross Medical Group, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not they are paid for by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (patient or parent if minor)

Date

Consent for Treatment

1. I voluntarily consent to such care including routine procedures and other treatment by Raincross Medical Group, Inc. professionals and their assistants, appointees, or consultants as is necessary in their judgment.
2. I am aware that the practice of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination by Inland Empire Weight Loss or Raincross Medical Group, Inc.
3. I understand that for certain procedures deemed necessary by my physician I will be required to sign a Special Consent Form.
4. I understand that Raincross Medical Group, Inc shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release by telephone, mail, fax, computer or personal delivery to any party responsible for my care, such information from my records as is required in order for the clinic and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement is received.

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Parent/guardian: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & accountability act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice. These include activities such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, training of residents and medical students, conducting clinical research, recruiting patients for research studies and providing customer service (such as conducting an internal quality assessment review).

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective and last revised as of February 18, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint you may contact:
The U.S. Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257 or 1-877-696-6775

Authorization to release information:

Do not release my information to anyone except as detailed in the HIPAA Notice of Privacy Practices.

Or,

I give permission to disclose medical information to the following:

Recipient: _____ Relationship: _____ Contact phone: _____

Recipient: _____ Relationship: _____ Contact phone: _____

Recipient: _____ Relationship: _____ Contact phone: _____

Recipient: _____ Relationship: _____ Contact phone: _____

Patient Rights and Responsibilities

Rights

- To receive service in a reasonable period of time.
- To receive medically necessary service
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have your medical coverage explained to you.
- To participate in treatment decisions.
- To refuse treatment
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
- To request review of your medical record by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.

Responsibilities

- Having appropriate identification, insurance membership cards, coverage stickers, etc at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship or a minor being treated.
- Providing a list of person who may receive medical information about you, on your behalf, in an emergency.

I have read and understand the HIPAA Notice of Privacy Practices and Patient's Rights and Responsibilities as stated above. These policies may change from time to time. I may request a current copy of this form at any time. I also agree to release (or not release) information as per the Authorization to Release Information Section:

Patient Name: _____

Signatory's Relationship to Patient: _____

Signature: _____ Date: _____

Appointment No Show / Cancellation Policy

Carl Knopke, M.D. / Inland Empire Weight Loss focuses on providing prompt and quality medical care to all of our patients, and we schedule our appointments accordingly. Each and every appointment space is important, and as a courtesy to all, we do not over book to compensate for those who fail to honor their appointments.

To help you keep track of your upcoming appointments, we have recently instituted an automated appointment reminder system. This system will either call you to confirm your appointment, or at your option, send you a text message to remind you of your appointment. These reminders will go out 2 evenings before your appointment. If you make an appointment for the next day, you will not receive a reminder for your upcoming appointment.

Our appointment no show/cancellation policy is necessary to maintain the high professional standards of our practice. Missed or cancelled appointment spaces deprive other patients of treatment and disrupt our efficiency. Our new no show/cancellation policy is as follows:

Cancel your appointment at least 24 hours prior (for Monday appointments, call our office by 2p on Friday)	No charge
Cancellation with less than 24 hours notice	\$20
Cancellation with less than 24 hours notice without new patient appointment fee paid.....	\$40
No show	\$40

New patients are expected to arrive with their paperwork completed or with adequate time to complete it before their appointment time. The estimated time for paperwork completion is between 20 to 30 minutes. There will be a \$20 fee required to make the appointment. This fee will be credited to your bill upon being seen.

If you are 20 minutes late or more to your appointment, you will be charged for the no-show and rescheduled, or you may be seen as a walk-in depending on availability.

The no show/cancellation fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Future appointments will not be made until the no show/cancellation fee is paid. Patients who no-show three or more times in a 12 months period may be dismissed from the practice. We reserve the right to change our fee schedule at our discretion.

We understand there may be unavoidable circumstances that will make you cancel your appointment, if you need to cancel or reschedule your appointment, **please give at least 24 hours notice. To cancel a Monday appointment, please call our office by 2 pm on Friday.**

Signature

Date

Name

DOB

Informed Consent for a Low Calorie Diet/Appetite Suppressant

Patient Name (print): _____ **Date of Birth:** _____

Appetite Suppressants: At the time of the writing of this consent form, there are 5 branded appetite suppressants on the market. These medications include Belviq, Contrave, Qsymia, Saxenda, and Xenical. Non-branded medications include diethylpropion, phendimetrazine, and phentermine. In addition, there are medications that are not appetite suppressants but which may be used to augment your weight loss efforts. Your provider may assist you with your decision in what is appropriate for yourself. Considerations may include the particular nature of the behavioral problem that is being treated, the cost of the medications, the expected length of the prescription time period, and relative and absolute contraindications from one medication that would favor another. At all times, the risk of your current health condition should be weighed against the risk/reward of using an appetite suppressant. You are not required to use an appetite suppressant to lose weight but results are typically better with one.

Appetite suppressants, such as phentermine, have package labeling which recommends the use of the medication for obese individuals, for time periods of up to 12 weeks, and at the dosage indicated in the labeling. Recently, national societies such as the Endocrine Society and the Obesity Medicine Association have issued position papers advocating for the longer term (> 12 weeks) use of phentermine as the risk/benefit analysis appears to favor the longer term usage. ‡, i, iv

Guidelines for Anorectic Usage: We adhere to guidelines for anorectic usage as stated by a variety of organizations such as the Obesity Medicine Association (OMA), AACE/ACE and the Endocrine Society. Pharmacotherapy generally is used as an adjunct to behavioral modification to reduce food intake and increase physical activity. Pharmacotherapy is indicated for the purpose of treating the disease of obesityⁱ which has a variety of definitions, preventing the relapse of obesity and to treat and lessen the risk of complications of weight related conditions. Indications for initiation and continuation of anorectics include:

- BMI ≥ 30 (Caucasians) and ≥ 27 in certain ethnic populations in normal healthy individuals^{*, iii}
- BMI ≥ 27 in individuals with co-morbidities (DM, HTN, insulin/leptin resistance, vascular disease, hyperlipidemia, asthma, cancer, GERD, OSA, kidney disease, osteoarthritis, gallstones, PCOS, psoriasis, acrochordon, acanthosis nigricans, or other related conditions)^{*, iii}
- BMI ≥ 25 with the above listed comorbidities and certain ethnic populations ≥ 23 with the above listed conditions[†]
- Current weight > 120% of a long standing healthy weight maintained after the age of 18ⁱⁱ
- Body fat $\geq 32\%$ in females and $\geq 25\%$ in males (obesity)^{*}
- Waist circumference $\geq 31''$ or $\geq 35''$ in women and $\geq 37''$ or $\geq 40''$ in men (increased and high risk)^{*†}
- Waist circumference in certain ethnic populations^{*†}:
 - Asians, Central and South American $\geq 31''$ in women and $\geq 35''$ in men
 - Europids, Middle Eastern $\geq 31''$ in women and $\geq 37''$ in men
- Any co-morbid condition that is aggravated by weight^{*}
 - Fat mass disease such as: hypertension, shortness of breath, impaired mobility, low self-esteem, body image dissatisfaction, decreased work productivity, negative self or external perceptions and others.
 - Sick fat disease such as: atherogenic dyslipidemia, increased triglycerides, insulin resistance, fatty liver, asthma, osteoarthritis, PCOS, hirsutism, low testosterone, intimacy problems, impaired fertility, prevention of cancer, sleep disorders, and others.
- Prevention of weight regain in a person who has previously lost weight^{i, iv, ‡}
- Weight loss for occupational needs^{*}
- Prevention of weight gain in a person who has a familial/genetic predisposition to obesity, cancer, or other obesity related conditions^{*}

* Obesity as defined by the OMA's Obesity Algorithm

ii – ASBP Overweight and Obesity Evaluation and Management guidelines – 2009

† AACE/ACE Clinical Practice Guidelines.

iii – FDA guidelines for anti-obesity medications

‡ Endocrine Society Clinical Practice Guideline

iv – OMA, pharmacotherapy position statement 2016

i – OMA position statement on anti-obesity medications – 3/2015

Off Label Prescribing... A provider is not required to use the medication as the labeling suggests. This is called off label prescribing and is specifically provided for by the FDA. I have found appetite suppressants and other non-anorectic type medications to be helpful for periods exceeding 12 weeks and at doses larger than those suggested in the labeling. The indications for these usages are based on my experience, the experience of my colleagues, and guidelines from the various medical societies. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects. I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant for the given dose and indication. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants and other non-anorectic type medications may give.

Dispensing and Furnishing: An appetite suppressant or other weight loss related medication may be prescribed and dispensed within the office. I understand that I have a choice in where I may obtain my prescription and that I may obtain it at a pharmacy of my choice.

_____ - By initialing here I agree that I have been given a choice in where I may obtain my medication.

Responsibility... It is my responsibility to follow dosing instructions carefully and to report promptly any medical problem(s) that may be related to my weight control program. In general, medications will not be prescribed without an office visit. One time, short term exceptions can be decided on a case by case basis. We reserve the right to refuse such an exception to anyone. Abuse of this policy can result in dismissal from the clinic. Diversion of medications to individuals other than myself is grounds for dismissal. Random urine drug testing may be done.

Purpose... I understand the purpose of this treatment is to assist me in my desire to achieve and maintain a healthy weight. My continuing to receive appetite suppressants will be dependent on my progress in weight reduction and weight maintenance.

Drug Testing: If you are drug tested as part of your employment or for another purpose, and you are prescribed a stimulant medication, you may test positive for methamphetamines. If needed, you may be given a doctor's note to state you are taking a medication to aid in weight loss.

Alternatives: There are multiple ways to decrease body weight and maintain a healthy weight. A reduced calorie diet or a protein sparing modified fast and regular exercise without the use of appetite suppressants could help, even though I may be hungrier and the weight loss may not be as great.

Risk of Proposed Treatment...The use of anorectic medications, involves some risk. Risks are higher for dosages that exceed the recommended labeling. Common side effects of stimulant type medications include: **insomnia, palpitations, dry mouth, headaches, psychological problems, medication allergies, short term high blood pressure, and dependence** (exceedingly rare). Blood pressure can become more elevated when taken with pseudoephedrine, an over the counter cold medicine. Rare, but serious risks include **primary pulmonary hypertension and valvular heart disease**. These side effects were observed rarely with fenfluramine and have a very rare occurrence with other appetite suppressants but have not been found to have a direct association. These risks could be slightly higher with Belviq (Lorcaserin), a weight loss medication that is similar to fenfluramine. Medications containing topiramate can increase the risk of cleft palate in a developing fetus. Medications containing liraglutide (Saxenda) can increase risk of thyroid cancers and pancreatitis. These and other possible risks could, on rare occasion, be serious or fatal.

*Your role: **Your success depends upon your commitment to fulfilling your obligations during treatment. You should be willing to:***

- Provide honest and complete answers to questions about your health, weight, eating, and lifestyle patterns.
- Devote the time needed to complete and comply with the course of treatment as prescribed.
- Attend your appointments regularly and follow your diet and exercise prescription.
- Obtain blood/diagnostic tests which your physician may deem necessary during your treatment.
- Advise the clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important. This affords the best chance of intervening before a problem becomes serious.

Risks Associated with Being Overweight: People who are overweight or obese have greater tendencies toward: hypertension, diabetes /metabolic syndrome/insulin resistance, high cholesterol, asthma, GERD, fatigue, heart attack, stroke, peripheral vascular disease, abnormal cardiac rhythms, obstructive sleep apnea, pulmonary hypertension, migraines, arthritis, low back pain, depression, anxiety, decreased fertility, PCOS, various types of cancer and other problems. ***These risks/conditions can be reduced with weight loss of as little as 5 percent.*** If you are taking medications for obesity related condition, dosages may need to be adjusted as your diet progresses.

Unknown Side Effects: The possibility always exists in medicine that the combination of a disease with methods employed for its treatment may lead to previously unobserved or unexpected effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary.

Common Side Effects: During a low calorie diet, common side effects can be: *a reduced metabolic rate, increased urination, dizziness, sensitivity to cold, a slower heart rate, dry skin, fatigue, diarrhea, constipation, bad breath, dry or brittle hair, hair loss, muscle cramps, or menstrual changes.* These responses are temporary and resolve when calories are increased after the period of weight loss.

Gallstones: Overweight people develop gallstones at a rate higher than normal weight individuals. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight, especially rapidly, may increase the chance of forming/developing stones or having complications of existing stones within the gallbladder. Should symptoms develop, commonly a right upper abdominal pain, or if you know or suspect that you have gallstones, let your provider know immediately. Gall stones may need a medication to treat the stones or surgery to remove the gallbladder. Less commonly, they may be associated with more serious complications or even death.

Pancreatitis: An inflammation/infection of the pancreas, may be associated with gallstones and/or obstruction in the bile ducts. The symptoms of pancreatitis are typically pain in the left upper abdominal area. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long term abuse of alcohol and the use of certain medications and increased age. Pancreatitis requires treatment and may be associated with more serious complications including death.

Pregnancy: If you become pregnant, report this to your health care professional and physician immediately. Your calorie restricted diet must be stopped promptly to avoid further weight loss and potential damage to a developing fetus. Anorectic medications used to facilitate weight loss are contraindicated during pregnancy. ***You must take precautions to avoid becoming pregnant during the course of weight loss.*** Your health care provider may help by prescribing birth control pills, referring for IUD placement or discussing other methods of birth control.

The risk of weight re-gain: Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors which favor maintaining a healthy body weight include regular exercise, adherence to a healthy diet, and having a coping strategy for weight regain before it occurs. Successful treatment may take months or years.

Sudden Death...Patients with morbid obesity and serious health problems such as severe hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without these 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.*** Other rare risks are primary pulmonary hypertension and valvular heart disease.

Food Items...Food items purchased in the office are non-returnable once purchased. "Warning: Food products sold in this office may contain lead which at certain levels is known by the state of California to cause cancer, reproductive harm or developmental harm." It is not possible for our suppliers to track all sources of lead in the production of the food including those that are naturally occurring in the soil.

Your Rights and Responsibility...You may leave treatment at any time. You have a responsibility to notify the physician that you are discontinuing treatment and to find another physician who is able to assume medical care for you after you leave treatment.

Consent – Low Calorie Diet/Appetite Suppressants: I, the undersigned, have reviewed the above information with my health care professional, regarding reduced calorie diets and appetite suppressants and understand/agree that the potential benefits of weight loss outweigh the risks of the proposed therapy. I have had an opportunity to ask questions and have had them answered to my satisfaction.

Participant Signature

Date