League City Spine and Sports Medicine PLLC
Patient Informed Consent for Appetite Suppressants

1. I,_____ authorize League City Spine and Sports Medicine PLLC to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks.

2. I have read and understand my doctor's statements that follow:
"Medications, including the appetite suppressants, have labeling worked out between the makers 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 dosages indicated in the labeling.
"As a clinic, we have found the appetite suppressants helpful for periods in excess of 12 weeks. We, are not required to use the medication as the labeling suggests, but do use the labeling as a source of information along with clinical experience, the experience of our colleagues, recent longer term studies and recommendations of university based investigators. Based on these, we have chosen, when indicated, to use the appetite suppressants for longer periods of time when clinically warranted.
"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 (as noted below).
"As a clinic, we believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time. 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 use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the provider 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.

4. 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.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange-eating program without the use of the appetite suppressant would likely prove successful if followed.

Risks of Proposed Treatment:
I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Risks Associated with Being Overweight or Obese:
I am aware that there are certain risks associated with remaining overweight or obese. Among them are high blood pressure, diabetes, heart attack and heart disease, and arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

No Guarantees:
I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

Patient's Consent:
I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR PROVIDER NOW BEFORE SIGNING THIS CONSENT FORM.

PATIENT'S SIGNATURE: _____ **DATE:** _____

TIME:_____

League City Spine and Sports Medicine PLLC
Weight Loss Program Consent Form

I, _____authorize League City Spine and Sports Medicine PLLC to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

○ I understand that there are no refills on any appetite suppressant prescriptions without an office visit _____ *(initial)*

○ I am not pregnant or trying to become pregnant _____ *(initial)* *or N/A*

○ I am not breast feeding _____ *(initial)* *or N/A*

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concern the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Patient's Signature:_____ **Time**:_____

Date: _____

League City Spine and Sports PLLC
Consent to Participate in a Telemedicine Consultation

Patient Name : _____

1. I understand that my health care provider, wishes me to engage in a telemedicine consultation with Dr. Bharat Mittal, M.D. (Medical Director), his NP-C if the need presents itself or one of the providers of League City Spine and Sports Medicine.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/ health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation; I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described here in.

   If you have any questions regarding telemedicine or the above, ask now before signing this consent form.

Date : _____ **Time** : _____

Patient :_____ **Guardian Signature**:_____

League City Spine and Sports PLLC
Prescription Policy

Patient Name :_____

League City Spine and Sports Medicine PLLC prescription medication policy is designed for your safety and well-being during treatment. Questions about the policy should be directed to our staff or your provider.

1. I understand that as a patient, I hold primary responsibility for my medications. **LEAGUE CITY SPINE AND SPORTS MEDICINE PLLC WILL NOT FILL OR REFILL / REWRITE MEDICATIONS OR SCRIPTS THAT ARE LOST, STOLEN OR DAMAGED IN ANY WAY.** All medications are controlled substances and it is your responsibility to take care of your medication.

2. If my medications are lost, stolen or misplaced, a replacement WILL NOT be given without a police report of the incident, specifically including your medication in the report.

3. **ALTERING PRESCRIPTIONS IS A FELONY**. If you alter or forge any prescription you may be prosecuted. **Use** of **illegal drugs** may result in ***immediate dismissal*** from this clinic. We will not treat any patient engaged or implicated in such criminal activities.

4. I will always take my medications as prescribed by my provider at League City Spine and Sports Medicine PLLC. If I feel that the medication or amount of medication prescribed is inadequate, I will contact the clinic, which may require an office visit for further consultation.

5. I will always keep track of the number of pills remaining, and schedule a follow-up visit as necessary.

6. **While I am receiving controlled-substance medications from League City Spine and Sports Medicine PLLC, I agree not to receive from another physician the same medication, same class of medication, or any medications that may interact without notifying League City Spine and Sports Medicine PLLC.**

7. I will not take any medications other than those prescribed to me by my doctors. I will not give my medication to others or "**borrow**" medications from others. I will let **ALL** of my treating **doctors** know **ALL** of the **medications** I am taking and why.

8. For my safety and optimal treatment, I will immediately inform League City Spine and Sports Medicine PLLC of any medications that I am actively taking. Not notifying my provider could increase my risk of adverse events, or even death from an overdose. Receiving controlled substances from another physician while receiving controlled-substance prescriptions from League City Spine and Sports Medicine PLLC without notice, could result in my immediate discharge

If you have any questions regarding our policies, please ask now before signing this consent form.

By signing below, I acknowledge that I have read these policies, understand these policies, and agree to abide by them fully.

Date : _____ **Time** : _____

Patient (Signature) :_____