Anew
Weight Loss Center, PLLC

PHENTERMINE/STIMULANT INFORMED CONSENT

I request the use of Phentermine/stimulants, 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/stimulants 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 Anew Weight Loss Center, PLLC. I understand there is no guarantee for the effectiveness of Phentermine/stimulants. I agree that I am and will be under the care of another medical provider for all other health conditions. Mrs. Staten, FNP (Anew medical provider) can work in conjunction with, but cannot replace, my regular primary care provider, such as general practitioners or other specialists in family medicine or internal medicine. I understand Mrs. Staten, FNP (Anew medical provider) can only prescribe Phentermine/stimulants and medication necessary for this treatment and all other health matters should be through my regular provider(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, etc.) thalessemia, hemophilia, mental disorders, 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.

Contraindications and Warnings

Patients with the following should not use Phentermine/stimulants:

- An allergy to Phentermine/stimulants
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension,
- Hyperthyroidism
- Glaucoma
- Are in an agitated state
- Have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant
- Bipolar depression (mania)

Patients with the following should take special precautions and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or
- high cholesterol or lipid levels

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Side Effects

While Phentermine/stimulants is generally free of negative side effects, there is the possibility of the following:

- Dry mouth
- Unpleasant taste
- Heartburn
- Skin Rash or Itching
- Diarrhea
- Constipation
- Stomach Pain
- Lactic acidosis
- Fatigue
- Nausea/ Vomiting
- Hypertension
- Insomnia or
- Restlessness

- **Less common side effects include:**
- Convulsions
- (seizures)
- Erectile Dysfunction
- Depression
- Panic attacks
- Fever
- Hallucination
- Tremors or shaking
- Fainting
- Overactive reflexes

I understand Phentermine/stimulant treatments may involve these risks and other unknown risks. I understand that use of Phentermine/stimulants is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Mrs. Staten, FNP if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. I agree to immediately report any problems that might occur to my primary 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.

I understand that I may quit the program at any time. In the event that an illness does occur, I understand that I need to contact Anew Weight Loss Center immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility. 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 Mrs. Staten, FNP 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 medical practitionr and the facility from any liability associated with this medication. In the event a dispute arises over the outcome of the treatment, I consent solely to arbitration as a legal means of settlement.

Patient's Name Printed: _____ Date: _____

Patient's Name Signed: _____

Provider's Name Printed: _____ Date: _____

Provider's Name Signed: _____