Aesthetics

EST. 2022

WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request strict dietary restrictions for the purpose of weight loss. 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 Maria Espinel APRN I agree that I am and will be under the care of another medical provider for all other conditions. Maria Espinel APRN 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 that Maria Espinel APRN can only prescribe weight loss related 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 pregnancy, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalessemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me.

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:______

There are side effects that can office but not limited to:

- Ovarian Hyper-stimulation Syndrome (OHSS) – which is a life-threatening condition
- Excessive fluid retention in the body tissues, swelling (edema), numbness/tingling, trembling
- Arterial Thromboembolism – another potentially life-threatening condition
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- Blood clots • Prostate hypertrophy
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- Abnormal enlargement of breasts in men(gynaecomastia)
- Hair Loss
- Difficulty breathing
- Over stimulation of the ovaries causing
production of many ova (eggs) in women
- Fast, irregular, pounding or racing heartbeat or pulse
- Tiredness and/or weakness • Headaches
- Change in Moods • Dizziness
- Irritation or skin rash in area of use • Unusual Sense of Wellbeing
- Chest pains • Mental Changes
- Low sex drive, Inability to have or keep anerection
- Hives, Skin Rashes
- Blurred vision or temporary blindness • Troubled with speaking

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- Convulsions • Difficult or painful urination
- Acne • Collapse/Fainting
- Bleeding/Bruising • Death

I understand weight loss treatments may involve these risks and other unknown risks:
Initials:_______

I understand that weight loss treatments are absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Maria Espinel APRN 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 Maria Espinel APRN 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 Maria Espinel APRN. at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by ME AESTHETICS for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. **Initials:_________**

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:____________________________
Patient's Name Signed: Date:________________________
Provider's Name Printed:___________________________
Provider's Name Signed: Date:_______________________

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