Transformations International, Inc.

EXTENDED PATIENT INFORMATION

NAME: _____ **CLINIC**: _____

PRIMARY EMAIL ADDRESS: _____ **DATE**: _____

Please circle the source below that brought you in **TODAY** (*please just circle one*)		If you have **ALSO** heard about Transformations from an additional source, please circle *one* below.
SAW OUR SIGN DRIVING BY		SAW OUR SIGN DRIVING BY
RECEIVED A GUEST PASS (from a friend or any other source)		RECEIVED A GUEST PASS (From a friend or any other source)
A FRIEND		A FRIEND
FOUND US SEARCHING ON THE INTERNET		FOUND US SEARCHING ON THE INTERNET
RECEIVED AN EMAIL ABOUT US		RECEIVED AN EMAIL ABOUT US
SAW OUR AD ON ANOTHER WEB SITE		SAW OUR AD ON ANOTHER WEB SITE
A NEWSPAPER AD(S)		A NEWSPAPER AD(S)
YELLOW PAGE AD(S)		YELLOW PAGE AD(S)
A MAGAZINE AD(S)		A MAGAZINE AD(S)
A RADIO AD(S)		A RADIO AD(S)
A TV AD(S)		A TV AD(S)
A DOCTOR TOLD YOU ABOUT US		A DOCTOR TOLD YOU ABOUT US
OTHER/CLARIFY (if possible, please indicate the event, occasion, specific radio, tv, email ad, or physician name): _____		**OTHER/CLARIFY** (if possible, please indicate the event, occasion, specific radio, tv, email ad, or physician name): _____

A FEW QUESTIONS THAT WILL HELP TRANFORMATIONS PROVIDE YOU BETTER SERVICES & OFFERS

1) Do you exercise? *IF YES,* where? home gym ____ health club ____ fitness video ____ other ____
IF NO , are interested in starting to exercise at this time? Y____ N____

2) What is motivating you most to lose weight? Health ____ Feel Different ____ Look Different? ____
Upcoming Event ____ Fit Into Clothes ____

3) What is your biggest hurdle to losing weight? Eating poorly ____ Don't know what/how to eat? ____
Lack of Exercise _____ Unable to stay on a diet ("willpower") ____ Don't know ____

4) Have you tried any other weight loss programs? Y____ N____ IF *YES* , with what organization/company?_____

5) Have you tried and/or using any other weight loss products? Y____ N____

6) Which one do you use most to search online? Yahoo ____ Google ____ Bing ____ Ask.com ____

7) How far do you have to drive to this clinic's location? 1 mile ____ 3 ____ 5 ____ 10 ____ 10+____

8) What radio station(s) do you listen to? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

Transformations International, Inc. Lake Mary Lee Road Oviedo Kissimmee Metro West Clermont Melbourne Tampa Tampa Tower Stuart Tulsa #2

B. Person(s) or Organization(s) authorized to receive the information:

Transformations International, Inc. Lake Mary Lee Road Oviedo Kissimmee Metro West South Orlando Clermont Melbourne Brandon-Tampa Tampa Tower Tulsa #2

C. Specific description of the information that may be used or disclosed (including date(s))

Lab results, weight, blood pressure, measurement records, medication as requested by myself for all dates treated

D. Specific description of how the information will be used:

Personal records to track weight loss

:

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1) I understand that this authorization will **expire** on _____.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Transformations International, Inc. in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.

HEALTH QUESTIONNAIRE

NAME	AGE	HEIGHT	DATE
ADDRESS		WEIGHT	PHONE

HISTORY OF PAST ILLNESS: Childhood				Yes	No
Have you had?	Yes	No	***Have you had?***		
Measles			Rheumatic fever or heart disease		
Mumps			Tuberculosis		
Chicken Pox			Venereal Disease		
Diabetes			Congenital Abnormalities		
Strokes			Other Serious Diseases:		
Cancer					

HISTORY OF PAST ILLNESS: Adult	Yes	No
Have you had any serious illnesses?		
Have you ever been hospitalized or been under medical care for very long?		
If Yes, for what reason?		

HISTORY OF PAST ILLNESS: Operations	Yes	No
Have you had any surgery?		
If Yes, Please List:		

HISTORY OF PAST ILLNESS: Injuries	Yes	No
Have you had any broken bones?		
Have you had any head concussions or injuries?		
Have you ever been knocked unconscious?		

FAMILY HISTORY						Yes	No
	If Living:	**Age**	**Health**	**If Deceased:**	**Age (at death) & Cause**	***Has any blood relatives ever had:***		
Father						Cancer		
Mother						Tuberculosis		
Brother/Sister						Diabetes		
						Heart Trouble		
						High blood pressure		
Husband/Wife						Sroke		
Son/Daughter						Convulsions		
						Suicide		
						Insanity		
						Bleeding tendency		
						Gout or other arthritis		

SOCIAL HISTORY

Circle One:

Alcoholic Beverages: Never Rarely Moderately Daily Ever?

Tobacco: Cigarettes _____ packs a day Don t smoke Ever smoked?

Are you exposed to fumes, dusts, or solvents?

SYSTEMIC REVIEW:				Yes	No
Do you have any of the following:	Yes	No	**Head-Eyes-Ears-Nose-Throat (cont d):**		
General:			Headaches		
Recent weight change?			Glaucoma		
Have you been in good general health most of your life?			Itching eyes or nose		
Skin:			Sneezing or runny nose		
Skin Disease			Nosebleeds		
Jaundice			Chronic sinus trouble		
Hives, eczema or rash			Ear disease		
Frequent infection or boils			Impaired hearing		
Abnormal pigmentation			Dizziness or short term episodes of unconsciousness		
Head-Eyes-Ears-Nose-Throat:			**Neck:**		
Eye disease or injury?			Stiffness		
Do you wear glasses?			Thyroid trouble		
Double vision			Enlarged glands		

HEALTH QUESTIONNAIRE

SYSTEMIC REVIEW (cont'd)	Yes	No
Respiratory:		
URI (cold) now		
Spitting up blood		
Chronic or frequent cough		
Asthma or Wheezing		
Difficulty breathing		
Any trouble with lungs		
Pleurisy or Pneumonia		
Cardiovascular:		
Chest pain or angina pectoris		
Shortness of breath with walking or lying down		
Difficulty walking two blocks		
Heart trouble or heart attacks		
High blood pressure		
Swelling of hands, feet,or ankles		
Awakening in the night smothering		
Heart murmur		
Gastrointestinal:		
Peptic ulcer (stomach or duodenal)		
Vomiting blood or food		
Gallbladder disease		
Liver trouble		
Hepatitis		
Painful bowel movement		
Bleeding with bowel movements		
Black stools		
Hemorrhoids or piles		
Recent change in bowel habits		
Frequent diarrhea		
Heartburn or indigestion		
Cramping or pain in the abdomen		
Does food stick in your throat		
Genitourinary:		
Loss of urine		
Frequent urination		
Night time urinating		
Burning or painful urination		
Blood in urine		
Kidney trouble		
Kidney stones		
Bright s Disease		

SYSTEMIC REVIEW (cont'd)	Yes	No
Gynecological:		
Age periods started:		
How long do periods last? days		
Number of pregnancies		
Number of miscarriages		
Date of last cancer smear and results		
Frequency of periods, every days.		
Any pain with your periods		
Number of children Ages		
Date of first day of last period		
Musculo-skeletal:		
Varicose veins		
weakness of muscles or joints		
Any difficulty walking		
Any pain in calves or buttocks on walking		
relieved by rest?		
Neuro-Psychiatric:		
Have you ever had psychiatric care?		
Have you been advised to see a psychiatrist?		
Do you ever have, or have had, fainting spells?		
Convulsions		
Paralysis		
Hematologic:		
Are you slow to heal after cuts?		
Blood disease		
Anemia		
Phlebitis		
Have you had difficulty with bleeding excessively		
after tooth extraction or surgery?		
Have you had abnormal bruising bleeding?		
Allergic:		
Any allergies, including medication		
Endocrine:		
Thyroid disease		
Hormone therapy		
Any change in hat or glove size		
Any change in hair growth		
Have you become colder than before or		
skin become dryer?		

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reactions or other adverse reaction or sickness following injection or oral administration of:

	Yes	No
Penicillin or other antibiotics		
Morphine, Codeine, Demerol, or other narcotics		
Novocain or other anesthetics		
Aspirin, empirin or other pain remedies		
Sulfa drugs		
Tetanus antitoxin or other serums		
Adhesive tape		
Iodine or merthiolate		
Any other drug or medication		
Any foods, such as egg, milk, or chocolate		

List other known allergies.

Have you ever received treatment for:	Yes	No
Asthma		
Rheumatism		
Rheumatic Fever		

2. Drugs Recently Taken: Withing the past 6 months	Yes	No
Cortisone		
ACTH		
Anticoagulants		
Tranquilizers		

	Yes	No
Hypertensive (high blood pressure medicines)		
Aspirin		

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Physician _____ Date _____ Signature of patient _____

PATIENT CONSENT AND DECLARATION FORM FOR WEIGHT CONTROL TREATMENT

1. _____ I hereby give consent to the physician(s) to render treatment for obesity and/or weight control, and said physician(s) has my permission to prescribe weight loss medication and injections of *Human Chorionic Gonadotropin* (hCG).

2. _____ I thoroughly understand Transformations weight control program and the procedures, and am fully aware that no guarantee or assurance has been given to me, as to the results which may be obtained from the weight loss program.

3. _____ I understand the physician(s) has given his/her permission for my participation in the weight control program; based solely on the medical history and background information I have provided, which I deem to be true and accurate.

4. _____ I assume all risk and responsibility and voluntarily release the mentioned physician(s), and his/her staff, from all claims that may be associated with Transformations weight loss program, with the exception of those attributable to negligence.

5. _____ I have been informed and am fully aware that the use of HCG (Human Chorionic Gonadotropin) by injection has the possibility to aggravate fibrocystic disease of the breast. Being fully informed and aware of this possibility, I elect to utilize the 125 units of HCG for my weight loss program.

6. _____ I have been informed and am fully aware that if I have a medical history of **uterine fibroids**, and/or **ovarian cysts** (female); or of **Prostatitis** (male), that the use of HCG (Human Chorionic Gonadotropin) by injection may be contra-indicated in my weight loss treatment.

7. _____ I have been informed and am fully aware, that the use of HCG has the potential to stimulate the production of estrogen (female), which in rare instances, may be inducible to pregnancy and/or multiple births.

8. _____ I have been informed and am fully aware that I can ***not*** be pregnant throughout the course of my medical weight control treatment, and that I should ***continue*** contraceptive practices.

9. _____ I have been informed and am fully aware that this prescription may be filled at any pharmacy or in this practitioner's office.

10. _____ I am fully aware and understand there is lack of scientific data regarding the potential danger of long-term use of combination weight loss treatments, and have been advised of the potential benefits versus the potential risks of such weight loss treatment.

11. _____ I understand my continuing to receive the appetite suppressants will be dependent on my progress in weight reduction.

12. _____ I am fully aware and understand that the need for dietary intervention, and physical exercise, should be a part of any weight loss regimen.

13. _____ I am suicidal.

☐ YES ☐ NO

14. _____ I am on probation or parole at this time.

☐ YES ☐ NO

15. _____ I am on a drug testing program or Methadone program.

☐ YES ☐ NO

16. _____ I will take medications prescribed only as directed.

☐ YES ☐ **NO**

PLEASE CONTINUE

17. _____ **I am not receiving treatment for any condition or prescriptions from any other doctors, except as stated below.**

_____ _____

_____ _____

_____ _____

(Doctor's name/address) (Rx, medications)

18. _____ I have been truthful to Transformations, International Inc. and the physician(s) about my medical and/or emotional problems.

☐ YES ☐ **NO**

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

CHILD PROOF CONTAINERS

☐ **I am requesting that Transformations International, Inc., NOT provide a child proof container with my medication.**

☐ **I have been given a child proof container. All medicine should stay inside the Transformations labeled prescription bag, all of which should stay inside the child proof container.**

Pt. received:_____(staff initial)

Date:_____

_____ _____

(Signature of Patient) **(date)**

DISCLAIMER

I am not currently being treated with any cardiac medications or serotonergic agents, including but not limited to: Fenfluramine, Dexfenfluramine, Phentermine (appetite suppressants), or over-the-counter weight loss medication, and/or herbal products, or any one of the Selective Serotonin Reuptake Inhibitors (SSRI's), or Monomanine Oxidase Inhibitors (MAOI's) for depression, or any of but not limited to, the medications listed below.

- **Prozac**
- **Zoloft**
- **Paxil**
- **Serzone**
- **Ludiomil**
- **Sinequan**
- **Vivactil**
- **St.John's Wort (herbal)**
- **Effexor**
- **Luvox**
- **Eldepryl**
- **Nardil**
- **Adapin**
- **Surmontil**
- **Anafranil**
- **Satiete (herbal)**
- **Parnate**
- **Desyrel**
- **Remeron**
- **Wellbutrin**
- **Asendin**
- **Tofranil**
- **Zyban**
- **Celexa**
- **Elavil**
- **Etrafon**
- **Limbitrol**
- **Norpramin**
- **Pamelor**
- **Triavil**
- ***Cardiac Medications:*** _____

Should I fail to inform Transformations or the physician(s), of the use and/or treatment with a Serotonergic agent (SSRI), or Monomanine Oxidase Inhibitor (MAOI), or any cardiac medication(s) while participating in the program, I assume all risks and hold Transformations International, Inc., and the physician(s), harmless from all claims associated with my use of any of, but not limited to, the medication(s) listed above. I have carefully read and fully understand all of the above information and declare it to be true and accurate.

_____
(patient's legal name)

_____
(witnessed by)

_____
(date)

☐ **Please check box if currently being treated with classes of medication mentioned.**

_____
(patient initial)

Female: I do not currently, nor in the past five years, have a medical history of uterine fibroids and/or ovarian cysts. I have no current or past medical history of polycystic ovarian disease. **Male**: I do not have a medical history of Prostatitis. Should I fail to inform Transformations International, Inc., or the physician(s) of a prior history, or an unknown history of the above mentioned condition(s), I assume all risk and hold Transformations International, Inc., harmless from any, and or all claims, associated with my use of HCG (Human Chorionic Gonadotropin). I have carefully read and fully understand all of the above information, and declare it to be true and accurate.

_____
(patient's legal name)

_____
(witnessed by)

_____
(date)

☐ **Please check box if patient currently has, or in the past five years has had uterine fibroids, ovarian cysts and/or polycystic ovarian disease. (Female); or Prostatitis (Male).**

_____
(patient initial)

***Note: The information contained in this disclaimer form is not intended to cover all drug interactions. This information is generalized and is not intended as specific medical advise. Always consult with your physician before taking any types of medication.**

MEDICATION ADVISORY FORM

The staff at Transformations hopes your experience with us will be pleasant as well as rewarding. To ensure your experience with us is pleasant, we want you to be aware there are several side effects and/or reactions to appetite suppressants. There is a possibility you may **not experience any** of these listed, however, the most typical or **more commonly** experienced side effects with using appetite suppressants are:

- **dryness of the mouth**
- **unpleasant taste**
- **occasional headaches**
- **diarrhea and/or constipation**
- **sleeplessness**

POSSIBLE SIDE EFFECTS

Appetite Suppressants: The medication may cause restlessness, dizziness, tremors, headaches, and/or depression. When taken as prescribed there are **rarely** any psychotic episodes. In some cases a patient **may** experience blood pressure elevation (our nursing staff will be monitoring this for you), rapid heart beat and/or pounding in the chest. The less common, but possible risks are: primary pulmonary hypertension and valvular heart disease. These and other possible risks could be serious or fatal. **Important: Doctors and Anesthesiologists require different lengths of time off different medications prior to surgery. In order to avoid any possible delay in your surgery, go off all medications from Transformations at least two weeks before your surgical date**.

How To Use This Medicine: Follow the directions for using this medicine provided by your Doctor. This medication may be taken with food. If you are using this medication on a regular basis and happen to miss a dose, take it as soon as possible. If it is almost time for your next dose, "skip" the missed dose and go back to your regular dosing schedule. **DO NOT** take two (2) doses at once. **Cautions:** When taking this medicine **alone** or with **other medicine(s)** and/or **alcohol**, avoid activities that require alertness and/or good Psychomotor coordination as it may affect your ability to drive and/or operate equipment, or perform other potentially dangerous tasks. **BEFORE YOU BEGIN TAKING ANY NEW MEDICINE** either prescription or over-the-counter, check with your Doctor or Pharmacist. If you are pregnant and/or will be nursing an infant **DO NOT** use this medication.

HCG: There may be some side effects to the HCG (Human Chorionic Gonadotropin). Below are several possible side effects to the injections. The more typical or **most commonly experienced** are: tenderness of the breasts, disruption in menstrual cycles (i.e. early onset or delayed - usually one week), and occasionally slight bruising at the injection site. The use of HCG has the potential to stimulate the production of estrogen which, in rare instances, may be inducible to pregnancy and/or multiple births. Other possibilities not generally seen which may occur in **male** patients are: tenderness in the groin, and/or aggravation to the prostate gland (if there is a continued history of prostatitis).

Possible adverse reactions which **may** occur include headache, irritability, restlessness, depression, fatigue, edema, precocious puberty, gynecomastia, and pain at the site of injection. Hypersensitivity reactions both localized and systemic in nature, including erythema, urticaria, rash, angioedema, dyspnea, and shortness of breath, have been reported. The relationship of these allergic-like events to the polypeptide hormone or the diluent containing benzyl alcohol is not clear. **Cautions**: If you are pregnant and/or will be nursing an infant **DO NOT** take this medication.

PLEASE DO NOT WAIT until your next visit to report these or any other side effects you may be experiencing to our nursing staff. Due to a wide variety of choices with selecting both the medication and strength, we can almost always help you become more comfortable.

I have carefully read and fully understand all the above information, and acknowledge the possibility of all risks with using the medications, and/or injections, in this program. I therefore assume all risks, and hold Transformations International, Inc., Medical Weight Loss Clinics, and the physicians(s), harmless to any, and/or all, reactions or side-effects experienced while taking any, and/or all, of said medications.

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

*The information contained in this advisory form is not intended to cover all possible uses, directions, precautions, drug interactions and/or adverse effects. This information is generalized and is not intended as specific medical advise.

METABOLIC ENHANCER DISCLAIMER

I have been informed and am fully aware that I can not take Metabolic Enhancer if I have any of the following conditions.

- High Blood Pressure
- Cardiovascular Disease
- Arrhythmias
- Diabetes
- Prostatic Hypertrophy
- Glaucoma
- Hyperthyroidism
- Psychosis
- Thyroid Disease
- Pregnant or Lactating

I have been informed and am fully aware that:

1. I can not take Metabolic Enhancer on the same day as Metabolic Enhancer Free.
2. I must inform Transformations and the Physician if I am now taking, or begin to take, asthma medications, appetite suppressing drugs, anti-depressants, or cardiovascular medication.
3. Caffeine intake is not recommended while taking the Metabolic Enhancer product.
4. I must be at least 18 years of age to take this product.
5. If allergic symptoms and/or reactions develop, I am to discontinue use.
6. This product contains Phenylalanine.
7. **Do not** take products containing Ephedra or Ma Huang in conjunction with Metabolic Enhancer.
8. **Do not** take Metabolic Enhancer if allergic to aspirin.

I acknowledge that I have carefully read and fully understand all of the above information. I assume sole responsibility and hold Transformations International, Inc., harmless for any, and/or all, reactions or side effects that may be experienced while taking the Metabolic Enhancer product.

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

METABOLIC ENHANCER FREE DISCLAIMER

I have been informed and am fully aware that I **can not** take Metabolic Enhancer Free if I am taking any Monoamine Oxidase Inhibitors (MAOI's) for depression or anxiety (for example: Eldepryl, Parnate, Nardil), or if I have any one of the following conditions.

- Hyperthyroidism
- Psychosis
- Parkinson's Disease
- Pregnant or Lactating

I have been informed and am fully aware that:

1. I can not take Metabolic Enhancer Free on the same day as Metabolic Enhancer.
2. I must inform Transformations and the Physician if I have hypertension, heart disease, arrhythmias, prostatic hypertrophy, glaucoma, liver disease, renal disease, or diabetes.
3. I will inform Transformations and the Physician if I am now taking, or begin to take, appetite suppressants or cardiovascular medication.
4. Caffeine intake is not recommended while consuming this product.
5. If allergic symptoms and/or reactions develop, I am to discontinue use.
6. I must be at least 18 years of age to take this product.
7. **Do not** take products containing Ephedra or Ma Huang in conjunction with Metabolic Enhancer Free.

I acknowledge that I have carefully read and fully understand all of the above information. I assume sole responsibility and hold Transformations International, Inc., harmless for any, and/or all, reactions or side effects that may be experienced while taking the Metabolic Enhancer Free product.

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

B-12 INJECTION DISCLAIMER

I have been informed and am fully aware that I can not take B-12 injections if I have Leber's Disease (disease of the nerve that is responsible for vision).

I have been informed and am fully aware that:

1. B-12 injection side effects and/or reactions may cause itching, rash, bumps, redness of the skin and/or mild discomfort at the injection site.
2. B-12 injection side effects and/or reactions may cause blood clots which can cause leg cramps, difficulty breathing, and/or stroke. If you have a history of blood clots, smoking and/or use oral contraceptives, you can be at an increased risk.
3. I must be at least 18 years of age to take this product.
4. If allergic symptoms and/or reactions develop, I am to discontinue use.
5. People with chronic liver and/or kidney dysfunction should not take frequent B-12 injections.
6. I should seek medical attention immediately if any severe side effects, including, but not limited to, severe allergic reactions (hives, difficulty breathing, tightness of chest, swelling of the mouth, face, lips or tongue), or lower back or side pain occur while using B-12 injections.

I acknowledge that I have carefully read and fully understand all of the above information. I assume sole responsibility and hold Transformations International, Inc., harmless for any, and/or all, reactions or side effects that may be experienced while taking the B-12 injections.

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

LIPOTROPIC INJECTION DISCLAIMER

I have been informed and am fully aware that I can not take Lipotropic injections if I have Leber's Disease (disease of the nerve that is responsible for vision) and/or a sulfa allergy (an allergic reaction to sulfonamides).

I have been informed and am fully aware that:

1. I must be at least 18 years of age to take this product.
2. Lipotropic injection side effects and/or reactions may cause itching, rash, bumps, redness of the skin and/or mild discomfort at the injection site.
3. Lipotropic injection side effects and/or reactions may cause blood clots which can cause leg cramps, difficulty breathing, and/or stroke. If you have a history of seizures, hypothyroidism, blood clots, smoking and/or use oral contraceptives, you can be at an increased risk.
4. Mild side effects may include upset stomach, bad breath, depression, incontinence, nausea, vomiting and diarrhea.
5. If allergic symptoms and/or reactions develop, I am to discontinue use of Lipotropic injection.
6. People with chronic liver and/or kidney dysfunction should not take frequent Lipotropic injections containing B-12.
7. I should seek medical attention immediately if any severe side effects, including, but not limited to, severe allergic reactions (hives, difficulty breathing, tightness of chest, swelling of the mouth, face, lips or tongue), or lower back or side pain occur while using Lipotropic injections.

I acknowledge that I have carefully read and fully understand all of the above information. I assume sole responsibility and hold Transformations International, Inc., harmless for any, and/or all, reactions or side effects that may be experienced while taking the Lipotropic injections.

_____ _____

(patient's legal name) (date)

_____ _____

(witnessed by) (date)

PATIENT MEDICATION CONSENT FORM

1) I _____ (patient and/or patient's guardian), authorize Transformations International, Inc., to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to the use of appetite suppressants, and when indicated, in different doses than the dose advised in the appetite suppressant labeling.

2) I have read and fully understand the following statements:
   - Medications, including the appetite suppressants, have labeling arranged between the makers of the medication and the FDA. 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.

   - Transformations International, Inc., and their physicians, have found the appetite suppressants helpful at times in slightly higher doses than those suggested in the labeling. Physicians are not required to use the medication as the labeling suggests. However, they do use the labeling as a source of information, along with the years of Transformations' experience, the experience of their colleagues, recent longer-term studies, and recommendations of university based studies. Based on these findings, they have chosen when indicated, to use the appetite suppressants at times in increased doses.

   - Such increased dosage has not been as systematically studied, as that suggested in the labeling. Therefore, the safety and efficiency of this therapy for weight loss has not been established.

3) I fully understand this authorization is given with the knowledge that the use of appetite suppressants in general, as well as in different doses than the dose indicated in the labeling, may involve risk(s) and/or adverse reaction(s). The more common include: nervousness, sleeplessness, headache, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat, and heart irregularities. The less common, but possible risks are: primary pulmonary hypertension and valvular heart disease. These and other possible risks could be serious or fatal.

4) I have carefully read and fully understand all the above information, and acknowledge the possibility of all risks using the medications, even at different dosages, in this program. I therefore assume full responsibility, and hold Transformations International, Inc. Weight Loss Clinics, and their physicians, harmless to any, and/or all, reactions or side-effects experienced while taking any said medications. I realize I <u>should</u> <u>not</u> <u>sign</u> this form if all items have not been fully explained, or if any questions I have concerning this consent have not been answered to my <u>complete</u> <u>satisfaction.</u>

_____ _____

(patient or person with authority to consent) (date)

_____ _____

(witnessed by) (date)