Active Body Wellness Hcg Weight Loss Program
Informed Consent

I_____, request injections of hcg 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 the injections myself. I understand that initial blood test might be necessary to rule out any conditions that would disqualify me from the program.

I understand Hcg is not FDA approved for weight loss as this application is considered "off-label use" and understand there is no medical evidence to support the use of hcg for this purpose. I agree that I am and will be under the care of another medical provider for all other conditions. The staff of Active Body Wellness can work in conjunction with, but cannot replace, my regular primary care provider. I understand that Active Body Wellness can only prescribe hcg and medication necessary for this treatment and all other health matter should be directed through my primary care provider.

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as trying to get pregnant, pregnancy, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled hypertension, seizure disorders, blood disorders (anemia, thalassemia, 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 Active Body Wellness from any liability associated with this procedure.

Initials_____

While hcg is generally free of negative side effects, there is the possibility of the following:

- Ovarian Hyper-stimulation Syndrome (OHSS) – which is a life-threatening condition
- Arterial Thromboembolism- another potentially life-threatening condition
- Blood clots
- Risk of pregnancy and multiple pregnancies (twins, triplets)
- Abnormal enlargement of breasts in men
- Over stimulation of the ovaries causing production of many ova (eggs) in women
- Acne
- Tiredness
- Changes in mood
- Irritation or skin rash in area of use
- Excessive fluid retention in the body tissues resulting in swelling (edema)
- Hair loss
- Prostate hypertrophy
- Difficulty breathing
- Collapse
- Death

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I understand hcg treatment may involve these risks and other unknown risks. I understand that use of hcg treawtment is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Active Body Wellness if I am pregnant, trying to get pregnant or become pregnant during these treatments. I understand that hcg is used in fertility treatments, and therefore I have an increased chance of pregnancy while on hcg, Multiple birth control methods should be used while on hcg. However, hcg is not contraindicated for women using IUD for birth control. 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 restriction, I agree to release Active Body Wellness and its associates 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 Active Body Wellness immediately. If I experience an emergency, I understand that I need to go to an emergency facility. I understand that if there are any changes in my medical history or are any changes in my medications or any other changes relevant to this program, I will advise Active Body Wellness at that time. Initials_____

Photographs: I given permission to Active Body Wellness to photograph treatment area(s) to be used for information kept in my file, and/or for teaching purposes, and/or promotional purposes. Complete patient confidentiality will be always maintained. Initials_____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the Active Body Wellness from any liability associated with this treatment. 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)_____

Patient's Signature _____Date:_____

Witness Name (printed) _____

Witness Signature _____Date: _____