Three Lakes MD Weight Loss & Wellness

Patient Informed Consent for Weight Loss Program and Appetite Suppressants

I. Procedure, Potential Side Effects and Alternatives:

1. I, _____ (patient), am aware that there are certain risks associated with being overweight or obese. Among them are tendencies for high blood pressure, diabetes, heart attack heart disease, arthritis of the joints, hips, knees and feet, and many other diseases. Obesity and being overweight also reduce my overall life expectancy. I understand these risks may be modest if I am slightly overweight but that these risks can go up significantly the more overweight I am. I recognize these current risks to my health as unacceptable and wish to treat my weight by enrolling in this program through Three Lakes MD Weight Loss & Wellness

I hereby authorize Dr. Jeter, and whomever she designates as her medical providers, to provide medical care for me to assist in my weight reduction efforts, to achieve the goals of weight loss and weight maintenance. I understand that such care may include but is not limited to physical examination, laboratory screening, EKG testing, instruction in behavior modification techniques, nutritional counseling, fitness counseling, vitamin supplementation, and the use of appetite suppressants.

2. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the product literature, and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

I have read and understand my medical providers' statements that follow:

"Medications, including 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 medical providers, we have found appetite suppressants helpful for periods more than 12 weeks, and at times in larger doses than those suggested in the labeling. We are not required to use the medication as the labeling suggests, but we do use the labeling as a source of information along with our own experience, the experience of our colleagues, and recent studies. 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."

"The more common side effects of the appetite suppressants 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, heart attack and stroke. Physical injury can result from such things as increased exercise and activity, and GI side effects, such as constipation, diarrhea, and/or bloating, or development of gallbladder disease, can occur from rapid weight loss. These and other possible risks could, on occasion, be serious or fatal. 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 may give you."

3. I understand that Glucagon-like Peptide-1 injections (semaglutide, tirzepatide, retatrutide) are prescription medications used for weigh loss. Do not take these medications if you have a personal or family history of Medullar Thyroid Carcinoma (thyroid cancer), have Multiple Endocrine Neoplasia Syndrome Type 2, have a history of pancreatitis, or are allergic to Semaglutide, Tirzepatide, or any other GLP-1 Agonist.

I understand that my use of semaglutide or tirzepatide may expose me to risks of various conditions, including but not necessarily limited to low blood sugar (glucose ≤70 mg/dL), fast tremors rate, sweating, shakiness, intense hunger, or confusion, nervousness, overstimulation, restlessness, dizziness, insomnia (inability to sleep), euphoria (sense of well-being), dysphoria (sense of unhappiness or depression), tremor, headache, dry mouth, diarrhea,

constipation, other gastrointestinal disturbance, medication allergies, impotence, or changes in libido. I further understand that my use of semaglutide or tirzepatide may expose me to the less probable but more serious risk of potential pancreatitis, cholelithiasis and cholecystitis (gallstone and gallbladder disease), thyroid disease, heart rate, gastroparesis, and dehydration. I am encouraged to ask questions as concerns may arise. I should promptly bring any questions I have to the attention of a qualified provider.

I understand that if I begin to experience any unusual or unexpected symptoms at any time after I begin using semaglutide or tirzepatide, I should immediately contact my provider. Unusual symptoms may include, but are not limited to, shortness of breath, edema (swelling of hands, legs or feet), heart palpitations or tachycardia (rapid heartbeat), nervousness, restlessness, insomnia, tremor, rapid breathing or respiration, or inability to tolerate exercise or activity. I understand that I may seek help from another qualified provider or go to a hospital emergency room.

I understand that I should use all GLPs in the manner prescribed by the provider and not provide this medication to any other person. I understand that I should not increase my dosage of semaglutide or use it with any other drug or substance without the recommendation of my provider. I also understand that I may stop using any GLP medication at any time in the future but should notify my provider before doing so.

4. I understand that if I am pregnant or I suspect I may be pregnant or I am trying to conceive, I should not be taking any prescription medications used for weight loss. I will notify Three Lakes MD Weight Loss & Wellness if I have any missed or irregular periods. I will use double-barrier protection methods against conception while on appetite suppressant medications.

5. I understand it is my responsibility to follow the instructions carefully and to report to the provider treating me for any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

6. 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 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 my life if I am to be successful. I understand my continuing to receive prescription medications for weight loss will be dependent on my progress in weight reduction and weight maintenance. I understand that any prescribed medication should be coupled with a diet rich in nutrition and a balanced exercise/physical activity regiment to attain the best results. I agree that medications may be sent to my provider on my behalf to be distributed to me.

Patient 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 prescription weight loss medications.

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 MEDICAL PROVIDER NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: ___/____/_____

PATIENT: _____

Effective Date: Sept 1, 2026
Reviewed Date:

Medical Director Name: _____
I, _____, the undersigning Physician, for the purpose of facilitating care within the general population, certify that the below protocol is appropriate for
providers registered under the clinic if they have had the proper education to perform the following examinations, assessments, and services, and are appropriately licensed and certified
to perform the following on the general population.

Clinic/Business/Provider Name: _____
Clinic/Business/Provider Responsible Party Signature: _____

Physician Name: _____
License Number: #_____
Physician Signature: _____
Date: _____