DasMD Clinic: Weight Loss Program

PATIENT'S NAME_____TODAY'S DATE_____

DOB_____SEX_____

PHONE NUMBER_____EMAIL_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

Strength	Weeks	Monthly price	Select & Initial
0.25 mg Semaglutide	4	$249	
0.5 mg Semaglutide	5	$295	
1 mg Semaglutide	5	$305	
1.25 mg Semaglutide	4	$305	
1.7 mg Semaglutide	5	$400	
2 mg Semaglutide	5	$400	
2.4 mg Semaglutide	4	$400	

Semaglutide	Guidelines
• Starting dose is 0.25mg/weekly and dose may be gradually increased every 4 weeks by the provider until a maintenance dose is achieved • Each month, the provided will select the appropriate dose depending on weight loss results, tolerance, side effects, etc (Note: You may not need the highest dose) • **Note: Once a vial is punctured/opened, it is recommended to use it within 28 days. After 28 days, it is NOT recommended to use the vial**	• Weekly visits are required for 1 month to learn how to administer the medication and for close side effect monitoring • After 1 month: during each monthly visit, you will be given 4 (or 5) weekly injections • Each visit will include measuring vitals, biometrics, and dietary counseling • Medication is being prescribed as part of weight loss program and not stand-alone therapy • **Monthly price of the medication is due in full at time of the purchase**

Patient Statement of Understanding I acknowledge all potential risks of starting a Medical Weight Loss program and have disclosed all medical history prior to starting this program. It is my responsibility to follow up weekly or as instructed by the medical provider and disclose any new medical history at every follow up visit recommended by the provider. I understand that medical weight loss program includes also adherence to advised lifestyle changes and it is my responsibility to adhere to the recommendations given in order to achieve my weight loss goals. I understand should my insurance not cover the medication recommended by my provider, I am solely responsible for the full price of the medication agreed upon in this signed contract. I understand that FULL payment for the program will be due at the time of service and that this payment is non-refundable. I acknowledge that program costs are according to established fees at the time the contract is signed and that there will be no submission of fees to a health insurance company and no refund will be made for the payment after the contract is signed and payment is made.

I have read and fully understand the above information related to insurance and participation DasMD Clinic Medical Weight Loss program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: _____

Printed Name:_____Date_____

Semaglutide/Tirzepatide Consent Form

Recommendations while using Semaglutide/ Tirzepatide:

- High fiber diet! (fruits and vegetables that are high in fiber)
- High protein small portion meals as digestion is slowed down while on this medication
- Avoid high fat meals (they take longer to digest)
- Limit alcohol intake as this medication can lower blood glucose
- Drink at least 80 oz of water daily to avoid constipation and nausea

Do not take this medication if:

- You have a personal or family history of medullary thyroid carcinoma (Thyroid Cancer)
- Multiple Endocrine Neoplasia Syndrome type 2 (MEN-2)
- You are pregnant or plan to become pregnant
- You are diabetic and/or taking any medications related to lowering your blood glucose levels without speaking with your provider. Specifically, if you are taking insulin as the combination may increase your risk of low blood sugar
- You have a history of Pancreatitis
- Allergic to Semaglutide or Tirzepatide, BPC-157, or any other GLP-1 Agonist such as Ozempic, Wegovy, Adiyxin, Byetta, Bydurteon, Rybelsus, Trulicity, Victoza. This product may contain inactive ingredients, which can cause allergic reactions. Before using this medication, tell your doctor your medical history.

Possible drug interactions:

Anti-diabetic agents, such as Insulin and Sulfonylureas (i.e., glyburide, glipizide, glimepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other agonist medicines such as but not limited to: Ozempic, Wegovy, Adiyxin, Byetta, Bydurteon, Rybelsus, Trulicity, Victoza.

Possible side effects:

Gastrointestinal symptoms such as nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distention, belching, hypoglycemia, flatulence, gastroenteritis, and gastroesophageal reflux disease. Subcutaneous Injections: common injection site reactions characterized by itching, burning at site of administration with or without thickening of thin skin (welting). If you notice any or other side effects not listed above, contact your doctor.

A very serious allergic reaction to this medication is very rare, however, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Report adverse side effects to your doctor. In event of any emergency, call 911 immediately.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THIS TREATMENT, OR ANY QUESTIONS CONCERNING THIS PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE STAFF NOW BEFORE SIGNING THIS CONSENT FORM.

By signing, I certify that I have read and understand the contents of this form. I am aware of the possible side effects and drug interactions and give my consent for treatment. I have informed the medical staff of any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed the medical staff of all medication and supplements I am currently taking; I understand there are other ways and programs that can assist me in my desire to decrease my body weight, and acknowledge that no guarantees have been made to me concerning my results.

Patient/Guardian Signature: _____

Printed Name:_____Date_____