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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation with ENT Clinic of Iowa P.C.
2. I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs. and allowing visits to be performed from the comfort of my home.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with ENT Clinic of Iowa P.C. and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through ENT Clinic of Iowa P.C. will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through ENT Clinic of Iowa P.C. is not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature: _____ Date: _____

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Medical Weight Loss Program Intake Form

Patient Name: (Last) (First) (MI)

_____

Patient Address:_____ City: _____State: _____Zip:_____

Phone Number: _____Email: _____

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name:_____ Relationship: _____

Phone: _____

How did you hear about us?_____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above. Sign:_____

Medical History

Medication Allergies:

_____

_____

Do you have a history of Pancreatitis? ____

Do you have a personal or family history of Medullary Thyroid Cancer? ____

Do you have a personal or family history of Multiple Endocrine Neoplasia Syndrome type 2?____

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Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc...): *

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

Any past surgeries and hospitalizations? *

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

Personal History

What are your main interests and hobbies?

What is your line of work or study?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

You have problems falling or staying asleep?

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How many hours do you sleep?

Do you wake up refreshed?

How is your energy?

Does your energy level affect your daily activities?

How would describe your mood, generally:

Does your mood affect your life or daily activities?

How would you describe your stress level?

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

Diet and lifestyle

Do you regularly drink alcoholic beverages?

If yes, how many per week?

Do you smoke tobacco?

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Do you use recreational drugs?

How is your appetite?

Snack Habits:

What:

How much:

When:

Typical Breakfast:

What:

How much:

When:

Typical Lunch:

What:

How much:

When:

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Typical Dinner:

What:

_____

How much:

_____

When:

_____

How often do you eat out?

_____

What restaurants do you frequent?

_____

How often do you eat "fast foods"?

_____

Food allergies?

_____

Food dislikes?

_____

Food cravings?

_____

Do you eat because of emotions (explain)?

_____

Do you drink coffee or tea? Yes No If Yes, how much daily?

_____

Do you drink pop / soft drinks? If yes, how much?

_____

Do you use sugar substitutes?

_____

What are your worst food habits?

_____

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How much fluids do you normally drink? Please approximate in ounces.

Please list all types of beverages you regularly drink.

Please list any food allergies, intolerances, or foods you avoid and the reason.

What past struggles and difficulties have you experienced in terms of food and dieting?

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

What types of diet and exercise approaches have worked for you in the past?

And what hasn't worked for you at all?

When did you first become overweight?

How did your weight gain start? Describe any circumstances:

What do you think is the cause of your weight problem?

What was your highest weight? (excluding pregnancy)

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What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How MOTIVATED are you to lose weight?

Is there anything else you would like to tell us?

Please list the factors you feel have contributed to your current weight (check all that apply):

Slow metabolism	☐
Family history of obesity	☐
Comfort food dependency	☐
Lack of exercise	☐
Binge eating	☐
Late night snacking	☐
History of trauma	☐
History of grief and loss	☐
Medication related weight gain	☐
Significant restrictive eating behaviors like anorexia	☐

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ENT Clinic of Iowa P.C. Clinical Policies

PATIENT CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT WITH ENT Clinic of Iowa P.C.

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____ENT Clinic of Iowa P.C. will not be submitting any charges to your health insurance company.

_____ I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

_____I understand that treatments used at ENT Clinic of Iowa P.C. might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that ENT Clinic of Iowa P.C. and Ashley Flattery A.R.N.P. are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at ENT Clinic of Iowa P.C.

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

_____I understand that having an appointment with ENT Clinic of Iowa P.C. does not necessarily entitle me to being issued a prescription for weight loss medication. Every individual is different, and it is at the medical providers discretion to issue a prescription.

_____I understand that I must maintain my follow up appointments to remain on treatment. It is important that Ashley Flattery A.R.N.P. manages my treatment and it is at their discretion to provide continued treatment.

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_____I acknowledge that I have been advised of the risks and benefits of treatment and that I have been provided a handout detailing this as well. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with ENT Clinic of Iowa P.C. and Ashley Flattery A.R.N.P. in regards to weight loss therapy as determined by a mutual decision between myself and the medical provider even if my weight is considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

_____I do not hold any medical practitioner of ENT Clinic of Iowa P.C. responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold ENT Clinic of Iowa P.C. and Ashley Flattery A.R.N.P. harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to ENT Clinic of Iowa P.C. as this could change the treatment prescribed to me.

I have read, understand and agree to all of the above statements.

Print Name:_____

Signature:_____Date_____

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Informed Consent for Medically Management Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with ENT Clinic of Iowa P.C. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

1. **Cardiovascular (heart or blood pressure):** These problems may include heart palpitations, irregular beats, or rapid heartbeat. These effects are usually mild but can result in serious problems including heart attack or stroke. Also, these medications may increase blood pressure, which if left untreated can lead to heart attack or stroke. If you discontinue the weight loss medication, the elevated blood pressure usually resolves. For this reason, if you are on blood pressure medications you are required to monitor your blood pressure daily and discontinue medications if blood pressure rise, your heart rate increases, or you feel palpitations. (Please initial) _____

2. **Sudden Death:** Patients with morbid obesity, particularly those with hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient. (Please initial) _____

3. **Reduced Potassium Levels:** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids, nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in electrolytes, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential. (Please initial) _____

4. **Gall Bladder Disease:** Any program resulting in rapid weight loss may precipitate the formation of gallstones, which could lead to cholecystitis (inflammation of your gallbladder), which is a medical urgency or emergency and could require surgery. This is

typically because of the rapid weight loss, not the medications you are taking. Symptoms include right upper abdominal pain, abdominal just below your ribs, nausea, and vomiting. (Please initial) _____

5. **Pancreatitis:** Pancreatitis, or an infection in the bile ducts, may be caused by gallstones or the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death. (Please initial) _____

6. **Psychiatric:** There are reported cases of "hysterical or psychotic reactions" associated with the use or discontinuation of some of the drugs utilized for weight loss purposes. These reactions are extremely rare. (Please initial) _____

7. Men over 40 and post-menopausal women in general, and patients with risk factors for cardiovascular disease should have a cardiovascular evaluation before entering a medically managed weight loss program. This may include an ECG, a stress test, or other testing procedures, as per the discretion of a cardiologist. If you are over the age of 40, post-menopausal (female), smoke, have a history of high blood pressure, high cholesterol or you are diabetic, you acknowledge that you have had a cardiac evaluation and that you have been cleared medically prior to starting this weight loss program. (Please initial) _____

8. Common, but troublesome side effects may include but not be limited to dry mouth, palpitations, "speedy" feeling, headaches, sleeplessness., Rash, fever, nausea, vomiting, allergic reactions, decreased insulin sensitivity, flushing, headache, fatigue, lightheadedness, abdominal cramping, joint pain, fluid retention, and additional side effects not listed that will be discussed during your evaluation with Ashley Flattery A.R.N.P. These side effects are generally rare, and most patients tolerate treatment without an issue. A handout will also be given. Please initial) _____

9. Drug interactions may occur if other medications are taken. Therefore, I will check with my prescribing medical provider before starting the program if I am taking other medications. (Please initial) _____

10. Certain medical conditions may be worsened if on this program, including glaucoma, hypertension, and heart disease. (Please initial) _____

11. Pregnancy (Females Only). If you become pregnant, inform your physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet

could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss. (Please initial) _____

12. The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 27 or higher with other medical conditions such as high blood pressure, diabetes, or high cholesterol. Prescribing medications for patients not fitting these criteria, is considered "off label" and not "FDA approved." Therefore, the potential risks vs. benefits may be great. For patients not fitting the BMI criteria for use of appetite suppression medication, you are acknowledging that:

    a. You have put forth a true effort to lose weight through diet and exercise over the past 6 months and have still not achieved your weight loss goals.
    b. That your inability to lose weight is causing significant emotional distress
    c. You are choosing to enter this medically managed weight loss program voluntary and hold harmless ENT Clinic of Iowa P.C. and Ashley Flattery A.R.N.P. for use of such medications.
    d. (Please initial) _____

13. You acknowledge that alcohol and illicit drug use is prohibited in the program. Drugs like cocaine and amphetamines when used in conjunction with appetite suppressants and other medications prescribed could cause in serious injury or death. The use of alcohol will also affect your results. (Please initial) _____

14. I acknowledge that I understand that the amount of weight loss varies from patient to patient, and is, to a large extent dependent on each patient's personal motivation and commitment to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed or implied. I understand the importance of routinely following up with ENT Clinic of Iowa P.C. to monitor my progress during treatment. I understand this is vital to the safety of the treatment program and certify that I will be returning monthly as prescribed. (Please initial) _____

15. I hereby authorize ENT Clinic of Iowa P.C., Ashley Flattery A.R.N.P. and additional staff of ENT Clinic of Iowa P.C., to evaluate me for admission into ENT Clinic of Iowa P.C., weight management program and treat me accordingly. I consent to obtaining blood work before treatment if deemed necessary. I certify that I am signing this under my free will and am competent to make my own medical decisions. (Please initial) _____

16. I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with medically managed weight loss therapy with ENT Clinic of Iowa P.C. I release any claim in court or any type of complaint that could result from treatment with ENT Clinic of Iowa P.C., Ashley Flattery A.R.N.P. and any other staff

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associated with ENT Clinic of Iowa P.C., and will not hold liable any provider or staff of ENT Clinic of Iowa P.C. (Please initial) _____

17. I understand that treatment modalities utilized by ENT Clinic of Iowa P.C. might not be supported by scientific/medical literature and could be seen as experimental or based off anecdotal claims. Many medical providers, including endocrinologists, surgeons, family practice doctors, etc., might see these types of treatments as not medically necessary. I also understand that many of the medications being utilized within ENT Clinic of Iowa P.C. medically managed weight loss program are considered to be used "off label" and might not be FDA approved for weight loss purposes. (Please initial) _____

By signing below, I acknowledge that I have had an opportunity any concerns and the above information with ENT Clinic of Iowa P.C. and Ashley Flattery A.R.N.P., either in person or by telephone conversation. I consent to the treatment being offered to me by ENT Clinic of Iowa P.C. and I am satisfied with the explanation. I acknowledge that I have read or have had read to me the above consent and understand the information presented.

_____

Signature of patient Date

_____

Printed Name of patient

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Risks and Benefits Acknowledgement

I recognize the potential risks of this treatment program, and I also understand the potential benefits of weight loss, which may include:

1. Decreased risk of heart attack.
2. Decreased risk of adult onset diabetes mellitus.
3. Decrease risk to developing arthritis or developing musculoskeletal conditions that are caused by excessive weight.
4. Increased emotional and psychological well-being.
5. Decreased risk of developing certain types of cancer.

I acknowledge that the medically managed weight loss program recommended to me by ENT Clinic of Iowa P.C. is just one of multiple strategies to reduce weight. Alternative treatment options include:

1. Diet and exercise alone without medications.
2. The use of other kinds of medications to achieve appetite suppression.
3. Non-medical weight loss programs like Weight Watchers.
4. Bariatric Surgery.

_____

Signature of patient Date

_____

Printed Name of patient

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My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at ENT Clinic of Iowa P.C. for medically managed weight loss services ENT Clinic of Iowa P.C. offers. I acknowledge I am not wanting to establish primary care with Ashley Flattery A.R.N.P. and I am here for specialized care including weight loss therapy.

Print: _____

Signature: _____

Date: _____

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Regaining Weight Acknowledgement:

There is a Risk of Regaining the Weight you have lost... Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it back over time. Factors which favor maintaining weight loss include exercise, adherence to a calorie that is low-calorie, nutritious, and full of lean proteins and vegetables, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Utilizing medications to assist you in your weight loss goals in addition to diet and exercise could result in the weight coming back if you do not maintain eating a healthy diet and exercising. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose.

_____

Signature of patient Date

_____

Printed Name of patient

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Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by ENT Clinic of Iowa P.C.; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by ENT Clinic of Iowa P.C.; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by ENT Clinic of Iowa P.C.; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by ENT Clinic of Iowa P.C. I am aware of the potential side effects associated with Semaglutide and/ or Tirzepatide provided by ENT Clinic of Iowa P.C, accept all the risks involved with these medications, and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____ Date:_____

Witness:_____ Date:_____