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 instruction on how to administer the injections myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them available before treatment starts. Initials: _____

I understand hCG is not FDA approved for weight loss as this application is considered “off-label use.” I 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. Amanda Milliken, NP can work in conjunction with, but cannot replace, my regular primary care physician, such as general practitioners or other specialists in family medicine or internal medicine. I understand Amanda Milliken, NP can only prescribe hCG and medication necessary for this treatment and all other health matters should be through my regular physician(s). Initials: _____

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as pregnancy, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorders (anemia, thalassemia, hemophilia, etc.), emphysema, asthma and any history of cancer or stroke. These contraindications have been fully discussed with me. If I fail to disclose any medical condition that I have, I release the healthcare provider and facility from any liability associated with this program. 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 lifethreatening condition Arterial Thromboembolism- another potentially life-threatening condition Over stimulation of the ovaries causing production of many ova (eggs) in women Excessive fluid retention in the body tissues, resulting in swelling or edema Risk of multiple pregnancies (twins, triplets, quadruplets) Abnormal enlargement of breast in men (gynecomastia) Blood clots Acne Tiredness Changes in mood Irritation or skin rash in area of injection Hair loss Prostate hypertrophy Difficulty breathing Collapse Death I understand hCG treatments may involve these risks and other unknown risks. Initials: _____

I understand that use of hCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Amanda Milliken NP if I am pregnant, trying to become pregnant or if I become pregnant during the course of these treatments. Initials: _____

hCG (Human Chorionic Gondotropin) CONSENT FORM (cont'd) I agree to immediately report to my medical provider any problems that might occur 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 restrictions, I agree to release the healthcare provider and facility 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 Amanda Milliken NP immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility. Initials: _____

I understand that if there are any changes in my medical history or there are any changes in my medication or any other changes relevant to this program, I will advise Amanda Milliken NP at that time. Initials: _____

PHOTOGRAPHS: I give permission for photographs (before & after) to be used by Amanda Milliken APRN for information kept in my file, and/or teaching, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. Initials: _____

I have read and fully understand the above terms. All of my questions have been addressed to my satisfaction. I agree to release the healthcare provider and facility from any liability associated with this program. In the event a dispute arises over the outcome of the program, I consent solely to arbitration as a legal means of settlement.

_____ _____

Patient's Printed (Print)

_____

Patient's Signature

Date _____

_____ _____

Provider's Printed (Print)

_____

Provider's Signature

Date _____