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### Semaglutide/Tirzepatide: Medical Weight Loss Program Consent Form

I \_\_\_\_\_ authorize Medfit of Georgia and DR/NP/PA and whomever they designate as their assistants, to help me in my weight reduction efforts.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Common risks of this program may include but are not limited to nervousness, sleeplessness, headaches, hypoglycemia, syncope, dry mouth, gastrointestinal disturbances, constipation, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion. Serious but rare reactions include, thyroid C cell tumor (animal studies), medullary thyroid cancer risk, hypersensitivity reaction, anaphylaxis, angioedema, acute kidney injury, chronic renal failure exacerbation, pancreatitis, cholelithiasis, cholecystitis.

Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain. 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 obesity may be a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior, including exercise, to be treated successfully.

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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form. If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever, concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_