

# REYNOSO MD

Medical Weight Loss Center

## hCG Weight Loss Program Consent

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I, \_\_\_\_\_, have chosen to participate in the hCG Weight Loss Program for weight loss, which includes diet, behavior changes and hCG administration. I am aware that the results may vary and are not guaranteed.

I understand that initial blood work, EKG and clearance from my primary care physician are required before starting the program. I agree to immediately report any problems that might occur including changes in health status or medications to REYNOSO MD and my primary care provider. I further understand that there could be risks involved as there are with all medications and that not complying with the dosage recommendations and dietary restrictions could increase risks and alter the results. I am aware that there are possible side effects which may include mild headaches, fatigue, bruising and/or swelling at the injection site. I understand that I could have an allergic reaction such as hives, difficulty breathing, and swelling of face, lips, tongue or throat. I understand that if I do have an allergic reaction that I seek medical attention immediately either by contacting my primary care physician or calling 911.

I understand that hCG is **not** FDA approved for weight loss. The FDA requires the following statement: "This weight reduction treatment includes the use of hCG, a drug which has not been approved by the Food and Drug Administration as safe and effective in the treatment of obesity or weight control. There is no substantial evidence that hCG increases weight loss beyond that resulting from caloric restrictions, that causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie restricted diets."

I agree that I have been counseled on a specific weight loss program for me with diet and hCG injections to attain my targeted weight loss. I must follow the program to achieve the desired results. I have been counseled on self-injection and assume full responsibility for myself. I also will dispose of used syringes properly. Patients who have been found to have submitted fraudulent material will be terminated from the program. Any medication is strictly for the use of the patient and not to be transferred or distributed, modified or used by any other party. I understand that hCG for weight loss is an off-label usage by a board certified physician and have read and understand all material provided by REYNOSO MD.

I understand that the payments that I have made associated with the hCG Weight Loss Program are non-refundable. It is the patients' responsibility to check their syringes prior to leaving the office. There will be a replacement fee for any hCG syringes that have been lost or mishandled. I understand that the hCG follow-up visits with Dr. Reynoso are only to discuss the hCG Weight Loss Program. If for some reason another topic is addressed during your office visit, you will be charged accordingly and responsible for the cost.

By signing below, I acknowledge that I have read the forgoing informed consent and agree to the hCG Weight Loss Program and its associated risks. I have disclosed my full medical history and have been physically examined by my health care provider. I am aware the significant or common risks, benefits, side effects and adverse reactions of hCG and I have had full opportunity to ask any questions. REYNOSO MD Medical Center and its staff, clinicians and/or physicians are not responsible for treatment of any medical condition disclosed by any abnormal reports or me. I agree to seek medical treatment for any identified medical problems with my primary care provider. I hereby release Dr. Joe M. Reynoso, clinicians and personnel of REYNOSO MD Medical Center from liability associated with this program.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_