HCG WEIGHT LOSS PROGRAM
INFORMED CONSENT

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 I will be instructed on how to administer the injections myself. I understand that initial blood tests will 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 ordered through Dr. Edward E. Dickerson, IV, MD. 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. Dr. Edward E. Dickerson, IV, MD can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand Dr. Edward E. Dickerson, IV, MD 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, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure. **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 life-threatening condition
- Arterial Thromboembolism - another potentially life-threatening condition
- Blood clots
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- Abnormal enlargement of breasts in men (gynaecomastia)
- Over stimulation of the ovaries causing production of many ova (eggs) in women
- Acne
- Tiredness
- Changes in mood
- Irritation or skin rash in area of use
- Excessive fluid retention in the body tissues, resulting in swelling (edema)
- 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 Dr. Edward E. Dickerson, IV, and MD if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. **Initials:**

I understand that HCG is used in infertility treatments, and therefore, I have an increased chance of pregnancy while on HCG. Multiple birth control methods should be used while on HCG. However, HCG is contraindicated for women
using IUD for birth control. Therefore, I agree to use condoms and/or abstinence as birth control method for the duration of the diet. **Initials:**

I agree to immediately report any problems that might occur to my medical provider 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 doctor 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 Dr. Edward E. Dickerson, IV, and MD 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 medications or any other changes relevant to this procedure, I will advise Dr. Edward E. Dickerson, IV, MD at that time. PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. Edward E. Dickerson, IV, MD for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. **Initials:**

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

**Patient’s Name Printed:**

**Patient’s Name Signed:** Date:

**Provider’s Name Printed:**

**Provider’s Name Signed:** Date:
HCG Patient Intake Form

Patient Name: (Last)________________________(First)________________________(MI)__________________
Patient Address: _________________________________________________________________
City: _______________________________ State: __________________ Zip: ______________________
Home Phone: ____________________________ Beeper/Cellular: ____________________________
Birthdates: ____________________________ Age: _______ Sex: M    F
Country of Birth: ______________________ Country of Parents’ Birth: ______________________
Education: Elementary  High School/Tech School  2-yr College  4-yr College   Grad. School (Circle Highest Level)

Employment Information:
Patient Employer: ______________________  Occupation: _____________________________
Employer Address: _________________________________________________________________
City: _______________________________ State: __________________ Zip: ______________________
Work phone No: ____________________________ Ext. ________________________________
Social Security: _________________________  Drivers License: __________________________

In Case of Emergency:
Name: __________________________ Relationship: ___________________ Phone: __________________
Patient’s Spouse: _______________________  Phone: _____________________________
Family Physician: ______________________  Phone: ________________________________
Referred by: ________________________________

Past History: (Please check if you have had any of the following):
☐ Allergies, Type: ______________________  ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis  ☐ Measles  ☐ Scarletina  ☐ Influenza
☐ Mumps  ☐ Diphtheria  ☐ Rheumatic
☐ Fever German Measles (3 day)  ☐ Polio  ☐ Whooping Cough
☐ Frequent Colds  ☐ Chickenpox  ☐ Tonsillitis  ☐ Scarlet Fever
☐ Pneumonia  ☐ Diabetes:Type: __________________________
☐ Cancer, Type: ______________________  ☐ Other Diseases ______________________
☐ Operations : ( dates) ______________________
Current Medications (vitamins, birth control pills): ________________________________
Any mood altering or depression medication: ________________________________
Allergies to medicines, foods, etc ________________________________

Family History:
Father: Health __________ Age _______ Deceased ___ at age ____ Cause ______________________
Mother: Health __________ Age _______ Deceased ___ at age ____ Cause ______________________
# of siblings: ______ # living_______ # deceased: ______ Cause ______________________

Family Diseases: Check diseases known in your blood relatives (not yourself)
☐ High blood pressure  ☐ Allergy  ☐ Heart trouble  ☐ Anemia
☐ Migraine  ☐ Bleeding (abnormal)  ☐ Dropsy  ☐ Epilepsy
☐ Strokes  ☐ Cancer  ☐ Diabetes  ☐ Nervous breakdown
☐ Kidney disease  ☐ Syphilis or (bad blood)  ☐ Suicide  ☐ Obesity
Arthritis  □  Rheumatic □  Fever □  Other _________________________

Examinations:
Date of last physical examination ______________ Reason: ________________________________
Hospitalizations ______________ Dates ______________ Reason: ________________________________
X-Rays: Chest ________ Stomach ________ Gallbladder ________ Kidney ________ Colon ________
Other ______________________________________________ Date of last laboratory tests: ________________
Electrocardiogram (heart tracing) ______________ Date of last pap (cancer smear): ________________

Do you now have or have had any of the following?
□ Itching  □  Eczema □  Hives □  Arthritis □  Limitation of motion □  Backache □  Muscle aches □  Leg pains □  Swelling, enlarged glands
□ Pain or stiffness (neck) □  Goiter □  Skin disease □  Lung disease □  Raised sputum □  Emphysema Bronchitis
□ Heart trouble □  High blood pressure □  Shortness of breath □  Palpitation or fluttering □  Chest pain □  Swelling of ankles
□ Indigestion □  Nausea or vomiting □  Abdominal pain □  Gas or bloating □  Diarrhea
□ Hard bowel movements ______ No. of bowel movements - daily ________ □  Colitis
□ Jaundice □  Hemorrhoids (piles) □  Bleeding or black stools □  Hernia
□ Urinary System □  Kidney disease □  Bladder disease □  Kidney stones
□ Painful urination □  Pu or blood in urine □  Albumen or sugar in urine
□ Dribbling of urine □  Varicose veins □  Nervousness or anxiety
□ Trouble sleeping □  Headaches □  Bored or depressed □  Nervous breakdown
□ Fainting □  Convulsions □  Numbness □  Loss of consciousness □  Paralysis

Menstrual History:
Menstruation began at age: _______ 28 day cycle? _______ If no, how many days? ________
Duration of bleeding: ______________ Pain with periods? ______________
Amount of flow: Light _______ Med. _______ Heavy ________
Date of 1st day of last: __________________________ menstrual period: __________________________
Bleeding between periods: ______________ Bleeding after intercourse: ______________
Irritation or discharge: ______________ Itching or burning: ______________

Weight History:
When did you first become overweight? (your age then) __________________________ (year) ______________
How did your weight gain start? Describe any circumstances: ________________________________

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

Your present weight: ______________ your weight goal: ______________ height: ______________
What was your highest weight? (excluding pregnancy) _______ your age then _______ # of years ago: _______
What was your lowest weight? _______ your age then _______ # of years ago: _______
Have you ever stayed the same weight for 10 years or more? Yes/No
Have you attempted to lose weight before? _______ most lbs lost: _______ how long it took: _______
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, and acupuncture) and describe your results: __________________________________________

Where and when do you do most of your overeating? __________________________________________

Please make any comments that you think might be helpful: __________________________________________
Financial Policy:
Thank you for selecting Dr.Dickerson for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient’s Signature ___________________________ Date ____________

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient’s Signature ___________________________ Date ____________
Form # 12-0007

Patient ID: 
Name: 
Birth Date: 

Specimen Order Number: 12-0007 - A
Dx: Fatigue 780.79
    Overweight 278.02

To Be Ordered: Lipid Panel, Cortisol, DHEA, Prolactin, RPR, Estrogen, Ferritin, 17-OH Progesterone, ANA, Fe, Thyroid Function Tests (T3, T4, TSH), CBC, BMP-7

Specimen Site:

Comments:

Any relevant previous biopsies: No

Instructions: Please Fax Results to 910-222-3068

Provider: Dickerson, IV, Edward E