Perspective Health
Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Patient Informed Consent for B12 Injections

Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take B12.

All medications and supplements have potential side effects, including B12. Most people tolerate B12 without issue, side effects are rare. Potential common B12 side effects include but are not limited to mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

You acknowledge:

1. That if I begin to have side effects, I will contact Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C immediately and notify them of what is happening.

2. I understand that although rare, vitamin B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects include rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.

3. Before starting vitamin B12 injections I agree to make Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C, aware if I have any of these conditions: Leber's Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that has an effect on bone marrow, or drug/supplement allergies.

4. I understand that there could be interactions with B12 and certain medications/supplements.

5. The use of B12 on a weekly to biweekly basis without a documented B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.

5. Caution is advised while taking B12 if you have a sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for B12 injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release Perspective Health, Tammy Chesley FNP-C, Rebecca Lucas FNP-C, and the person injecting the B12 of any damages or liability if anything was to occur.

Name: _____ -

Signature: _____ Date: _____

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Female Informed Consent to Treat

The Nature of the Treatment
I hereby give my consent to evaluation and treatment by Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and other healthcare practitioners of the following specified condition(s):

☐ Women: menopause or menopausal symptoms (including potential repletion of estrogen/estradiol, progesterone, DHEA, testosterone)

☐ Women: other hormone imbalances - Thyroid abnormalities, Adrenal abnormalities

☐ Women: other – Nutritional deficiencies, IV infusion services, weight loss, etc. (any other type of treatment services you might want to offer)

In addition:

☐ I acknowledge that treatment with testosterone, bioidentical hormone replacement therapy, B12, and thyroid optimization are considered off label use of the associated medications and have not been FDA approved for the use of health optimization, wellness, weight loss and/or for anti-aging purposes unless there is true medical necessity.

I agree to the administration of hormone replacement therapy and drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition, and treatment objectives.

Initial: _____

Alternative Treatments

I have been informed about alternative treatments and understand:

1. That we can leave the hormone levels alone.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bioidentical in nature (synthetics)

☐ I understand the alternative treatments and am choosing to consent to the treatment plan prepared for me by Perspective Health to address the condition/conditions listed above.

Initial: _____

Side Effects and Potential Risks

☐ Women: I understand that the possible side effects for women on estrogen, progesterone and/or testosterone may include breast swelling and/or discomfort, fluid retention, dizziness, thickening of the lining of the uterus (break-through bleeding), acne, unwanted hair growth, headaches, slight deepening of the voice, slight enlargement of the clitoris, potential increased risk of blood clots, and worsening of (1) ovarian cysts, (2) uterine fibroids, (3) endometriosis, and (4) fibrocystic disease.

☐ Women: I understand that the possible serious side effects for women on hormone replacement therapy including estrogen, progesterone and/or testosterone can be an acceleration in the growth of gynecological cancers, elevations in hematocrit which could potentially predispose one to a blood clot, and cardiovascular disease including heart attacks, strokes, and blood clots.

Most of the common side effects resolve with time. Many of these can be treated by changing your testosterone dose and adding other medications.

I acknowledge that I should take extreme precaution if I am to use topical testosterone products. If a child or women accidently is exposed to the testosterone cream/lotion on my body, it could cause a significant increase in their hormone levels which could result in possible side effects.

Initial: _____

Safety of Hormone Replacement

Although, in my medical providers opinion, majority of data points toward safety, there remains controversy regarding the correlation between the use of bioidentical hormone therapy and cancer. Recent data demonstrates that natural progesterone and estriol/estradiol may be protective against breast cancer.

Available data supports the safety of hormone replacement therapy in women, and it is of the opinion of Perspective Health, Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C that treatment is safe, but there still remains controversy regarding the correlation between the use of bioidentical hormone replacement and cardiovascular events such as but not limited to: strokes, heart attacks, and blood clots. Some studies have shown correlations between hormone replacement therapy and cardiovascular disease while others show no correlation or even a benefit in preventing cardiovascular disease.

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand that Perspective Health, Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C will monitor my hormone levels and various other laboratory values as they pertain to my treatment goals. However, I also understand that an integral part of health maintenance is obtaining and remaining up to date with age-appropriate screening tests aimed at early detection of life-threatening diseases.

☐ I understand that close monitoring is required by all patients to minimize and prevent any possible risks. I understand that Perspective Health will monitor my blood work including hormone levels. I also understand that it is important to stay up to date with routine screening and health maintenance by my primary care provider to prevent and detect any possible life-threatening diseases or conditions.

☐ I agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to: DEXA scans, mammograms, PAP smears, pelvic exams, colonoscopies, cardiac screenings,

and any other type of recommended health screenings. I agree to obtain these screenings through the direction of my primary care provider and/or OB/GYN and/or cardiologist and will not hold Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, or any additional Perspective Health staff responsible or liable for performing these health maintenance screenings or the treatment of any other conditions not relevant to my treatment goals with Perspective Health.

☐ Perspective Health, Tammy Chesley, FNP-C, and Rebecca Lucas, FNP-C strongly recommend obtaining yearly mammograms. I understand that certain types of breast cancer, once present, can be stimulated to grow faster by estrogen that is prescribed or even the estrogen within your body. Taking estrogen therapy with an active breast cancer could potentially decrease your chances of survival. Therefore, it is imperative to obtain appropriate yearly screenings.

☐ I agree to notify Perspective Health, Tammy Chesley, FNP-C, and/or Rebecca Lucas, FNP-C immediately if I am to become pregnant while on hormone replacement therapy and to stop it immediately. I understand that being on hormone therapy and becoming pregnant could present a risk to an unborn child.

☐ I want to initiate treatment at Perspective Health, and I give permission to Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and additional staff of Perspective Health to begin treatment without knowing results of age-appropriate and health maintenance screenings. In doing so, I release Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and other healthcare practitioners of any claims of liability for cardiovascular events, ovarian cancer, breast cancer, uterine cancer, cervical cancer and/or colon cancer. Further, I agree to immediately notify Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C and additional staff of Perspective Health of any abnormal findings on any health screenings done by my primary care provider.

Initial: _____

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 hormones and/or 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 or an OB/GYN or a Women's Health Specialist 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 Perspective Health for the specific services Perspective Health offers. I acknowledge I am not wanting to establish primary care with Perspective Health, and I am here for specialized care including hormone restoration, weight loss therapy, peptide therapy etc.

I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with hormone restoration and treatment with Perspective Health. I release any claim in court or any type of complaint that could result from treatment with Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and any other staff associated with Perspective Health and will not hold liable any provider or staff of Perspective Health.

I understand that treatment modalities utilized by Perspective Health might not be supported by scientific/medical literature and could be seen as experimental or based off anecdotal claims. Many

medical providers, including endocrinologists and OB/GYNs, might see these types of treatments as not medically necessary.

Initial: _____

Consent

I hereby authorize Perspective Health, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C and additional staff of Perspective Health to evaluate and treat conditions that I have consented for. I consent to obtaining blood work before treatment so hormone levels can be monitored, and appropriate treatment can be prescribed. I certify that I am signing this under my free will and am competent to make my own medical decisions.

Name: _____

Signature: _____ Date: _____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C, medical providers employed by Perspective Health and their respective officers, directors, employees, stockholders, assigns, successors and affiliates 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, Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, medical providers employed by Perspective Health and rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, of Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C of harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Tammy Chesley, FNP-C and Rebecca Lucas, FNP-C or Perspective Health. I am aware of the potential side effects associated with the above treatments, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Name: _____

Signature: _____ Date:_____

Today's Date:

Patient Information

First and Last Name: DOB:

Address:

City: State: Zip Code:

Cell Phone: Home Phone:

Email:

Occupation: Employer:

Ethnicity: Please select all that apply

☐ Hispanic ☐ Caucasian ☐ African American ☐ Asian ☐ Other: _____

Health Insurance (if needed for lab work):

Insurance Company:

Policy ID #: Group #:

Preferred Pharmacy:

Pharmacy: Cross Streets:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Gender:

☐ Male ☐ Female

How did you hear about us? _____

Who is your Primary Care Physician? _____

Health History Questionnaire

Name:	DOB:	Today's Date:

Allergies	Reaction (i.e., hives, rash, anaphylaxis, etc.)

PLEASE LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS		
Medication	**Strength**	**Use (i.e., 2 tablets twice a day)**

HEALTH MAINTENANCE			
Exam	**Date of exam**	**Exam**	**Date of exam**
☐ Recent labs		☐ Physical exam	
☐ Prostate exam		☐ Echocardiogram	
☐ Pap Smear		☐ Colonoscopy	
☐ Mammogram		☐ EKG	
☐ Dexa Scan		☐ Eye exam	

Name:	DOB:	Today's Date:

MEDICAL HISTORY
Please mark the appropriate boxes to indicate if you have been diagnosed with any of the following

Neurology

- ☐ Stroke (CVA)
- ☐ Transient Ischemic Attack (TIA)
- ☐ Seizures/Epilepsy
- ☐ Dementia
- ☐ Parkinson's
- ☐ Migraine

Endocrine

- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Osteoporosis

Cardiac

- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Angina or Frequent Chest Pain
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Rheumatic Fever

Lungs

- ☐ Asthma
- ☐ COPD (Emphysema)
- ☐ Sleep Apnea
- ☐ Valley Fever
- ☐ Tuberculosis

Urinary

- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis

Gastrointestinal

- ☐ GERD or reflux
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ H. Pylori
- ☐ Stomach Ulcer
- ☐ Pancreatitis
- ☐ Cirrhosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Barrett's Esophagus
- ☐ Lactose Intolerance
- ☐ Celiac Sprue
- ☐ Hiatal Hernia
- ☐ Hemorrhoids
- ☐ Gallbladder Disease

Rheumatology

- ☐ Osteoarthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Lupus

Blood

- ☐ Anemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ HIV/AID

Circulation

- ☐ DVT
- ☐ Pulmonary Embolism
- ☐ Peripheral Vascular Disease
- ☐ Carotid Artery Disease

Psychiatric

- ☐ Anxiety Disorder
- ☐ Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Schizophrenia

Please list any SURGERIES or PROCEDURES you have had:

_____

_____

Name:	**DOB:**	**Today's Date:**

FAMILY MEDICAL HISTORY

☐ **Adopted** If you are adopted and you do not know your family medical history, please check this box and skip the rest of this Family Medical History section.

	Mother	Father	Sister(s)	Brother(s)
Living	☐	☐	☐	☐
Deceased	☐	☐	☐	☐
Age at death	_____	_____	_____	_____

	Mother	Father	Sister(s)	Brother(s)	Other
Alcoholism	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐
CAD	☐	☐	☐	☐	☐
CHF	☐	☐	☐	☐	☐
COPD/Emphysema	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Irritable Bowel	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Vascular Disease	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Name:	**DOB:**	**Today's Date:**

WOMEN ONLY: GYNECOLOGY & PREGNANCY

Age of first menses: _____ Date of last menses: _____ Duration of flow: _____ days

Heavy Flow? ☐ Yes ☐ No ☐ N/A

PMS? ☐ Yes ☐ No ☐ N/A

Abnormal Discharge? ☐ Yes ☐ No

# of pregnancies: _____ # of miscarriages: _____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently trying to become pregnant? ☐ Yes ☐ No

TESTOSTERONE MEDICAL HISTORY & REVIEW OF SYSTEMS

Please mark the appropriate boxes to indicate if YOU or a FAMILY MEMBER have EVER been FORMALLY diagnosed by a medical provider with any of the following conditions

	Self	Blood relative (list relation)
High Blood Pressure	☐	☐ _____
High Cholesterol	☐	☐ _____
Diabetes	☐	☐ _____
Stroke	☐	☐ _____
Heart Attack	☐	☐ _____
Coronary Artery Disease	☐	☐ _____
History of Blood Clots	☐	☐ _____
Prostate Cancer	☐	☐ _____
BPH (enlarged prostate)	☐	☐ _____

Have you ever been on testosterone replacement therapy? ☐ Yes ☐ No

Please mark the appropriate boxes to indicate if you have ever experienced the following conditions or medical evaluations

	Yes	If yes, please explain:
History of kidney, bladder, or prostate infections	☐	
History of testicular trauma	☐	
History of head trauma	☐	
History of referral to Cardiology	☐	

Name:	**DOB:**	**Today's Date:**

NEUROPSYCHOLOGICAL

Have you ever received psychiatric treatment?	☐ Yes	☐ No
Have you ever considered or attempted suicide?	☐ Yes	☐ No
Do you have nervous habits?	☐ Yes	☐ No
Are you on any antipsychotic medications?	☐ Yes	☐ No
Do you ever experience episodes of mania?	☐ Yes	☐ No

SOCIAL HISTORY

Sex	Are you currently sexually active? ☐ Yes ☐ No
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks If yes, how many caffeinated drinks do you have in an average day? _____
Alcohol	☐ None ☐ Beer ☐ Wine ☐ Liquor If yes, how many alcoholic drinks do you have in an average week? _____
Tobacco	☐ Never smoked ☐ Current smoker: packs/day _____ # of years _____ ☐ Former smoker: packs/day _____ # of years _____ ☐ Current chewing tobacco: # of years _____ ☐ Former chewing tobacco: # of years _____
Marijuana	☐ Never ☐ Vape ☐ Edibles ☐ Flower ☐ Medical ☐ Recreational If yes, how often do you use marijuana?
Drugs	Do you have a history of recreational drug use? ☐ Yes ☐ No Have you ever used needles to inject drugs? ☐ Yes ☐ No

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Informed Consent for Peptide Therapy

Please initial each point acknowledging you have read and understand each one:

Peptides are amino acids that have biological activity which mimic certain hormones within the body. Peptides have the ability of increasing certain naturally producing hormones within the body to illicit a certain effect which will be discussed by Perspective Health. Certain peptides are FDA approved for the treatment of various diseases while other peptides are investigational new drugs that are not FDA approved to be marketed for consumption in humans even though clinical trials have shown them to have a favorable safety profile.

Initial: _____

Peptide therapy for the purpose of preventative care, weight loss, performance enhancement, anti-aging, and any additional condition discussed by Perspective Health is considered by the FDA to be "off-label use."

Initial: _____

Peptide therapy can be administered either orally, subcutaneously, intramuscularly, intravenously, or intranasally. The various preparations will be discussed with me by Perspective Health.

Initial: _____

Peptide therapies being administered by Perspective Health are prepared by registered compounding pharmacies that comply with all state and federal regulations.

Initial: _____

I acknowledge that Perspective Health is not responsible for any manufacturing issues related to peptides prepared by compounding pharmacies and that the sole responsibility for sterility, potency, and safety lie with these pharmacies.

Initial: _____

I understand that peptide therapies are not necessarily approved for my medical conditions, and they are not a medical necessity, rather, they are an adjunctive and complimentary therapy to my treatment plan. Therefore, I acknowledge that it is an elective treatment option.

Initial: _____

(WOMEN ONLY) There has been little research regarding the safety of peptide therapy in pregnant and breast-feeding women. I certify that I am not pregnant nor plan on becoming pregnant while on peptide therapy.

Initial: _____

I understand that with any drug, peptide therapies can carry potential side effects, including but not limited to:

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 Perspective Health.

Initial: _____

I understand that alternatives to peptide therapy are:

- Doing nothing
- FDA approved standard medication treatments
- Referral to specialists.
- Surgery

I acknowledge that there are no guarantees relating to the efficacy of peptide therapies and that Perspective Health is not responsible for my individual performance and ability to also exercise and diet.

Initial: _____

I certify that I will notify Perspective Health immediately if I have any concerns or side effects.

Initial: _____

I certify that I have had the risks and benefits discussed with me about peptide therapy and that I have had all my questions and concerns answered to my satisfaction by Perspective Health.

Initial: _____

I hereby voluntarily consent to be evaluated and treated by Perspective Health with the goal of improving my health, performance, and possibly delaying the effects of aging through peptide therapies.

Initial: _____

Name: _____

Signature: _____

Date: _____

Perspective Health
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Patient Informed Consent for Medical Weight Loss with the use of Phentermine

If applicable, and if deemed medically qualified and appropriate, I hereby authorize Perspective Health to assist me in my weight reduction efforts. I understand that my treatment program consists of a balanced diet, a regular exercise program, instruction in behavior modification techniques, possibly meeting with a registered dietician, and the use of the appetite suppressant medication Phentermine. I also understand that regular medical visits will be necessary while on the medication and that Phentermine must be used with caution and under direct supervision of Perspective Health.

Risk of proposed treatment: I understand that any medical treatment may involve risks as well as the proposed benefits of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risk. Risks of Phentermine include but are not limited to nervousness, diarrhea, constipation, sleeplessness, headache, tremor, fever, fainting, dry mouth, rash, change in libido, difficulty urinating, shortness of breath, swelling of feet or ankles, tiredness, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, hallucinations, stomach cramps, high blood pressure, palpitations, arrhythmias, rapid heart rate, and gallstones. Although seen only in rare cases, pulmonary hypertension, or heart valve disease may develop. The latter two conditions are serious and can be fatal. In case of serious side effects, stop taking the Phentermine and seek immediate medical assistance. In addition, Phentermine can be addictive and should not be used with a history of drug dependence. I also understand that there are certain health risks associated with remaining overweight or obese including high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, sleep apnea, and sudden death.

I further understand that Phentermine should not be used by people who suffer from heart disease, glaucoma, history of a stroke, liver or kidney disease, those with a history of drug dependency, alcoholism, psychotic illness, uncontrolled hypertension, advanced atherosclerosis, thyroid overactivity, people who are on MAOI's, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medications: Decongestant medications (Sudafed/Pseudoephedrine, Tylenol Sinus, Claritin D, Zyrtec D and Allegra D), Stimulant medications, high doses of caffeine, other weight loss medications, ephedrine MAO inhibitors, alcohol, antipsychotic medications, and thyroid medications.

Patient responsibility: As the patient, I understand it is my responsibility to follow instructions carefully, and to report to Perspective Health any significant medical problems that I think may be related to my weight control program as soon as possible. I agree to notify Perspective Health of any medical problems that I may have, or any results of labs/tests ordered and reviewed by any other physician. I further acknowledge that I enter this program in full knowledge and understanding that no physician, advanced practice provider, or staff of Perspective Health has prior knowledge as to whether I would or would not have adverse effects since each individual has a different biological and chemical makeup. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive Phentermine will be dependent on my progress in weight reduction and weight maintenance. I understand that a balanced caloric intake combined with regular exercise without the use of Phentermine may likely prove successful if followed, even though I would be hungrier than without the suppressant.

I am also in full understanding that Phentermine will be used no longer than 3 consecutive months. After 3 months of use the medication will be discontinued. If you and Tammy Chesley, FNP-C and/or Rebecca Lucas, FNP-C agree to use the medication longer than 3 months or if your BMI has decreased below the Federal Drug Administration's recommended value you will be using the medication in an off-label manner.

Phentermine may result in lethargy or depression with abrupt discontinuation, and I understand that during the program, medications will be discontinued if:

- I become pregnant, try to become pregnant, or suspect that I am pregnant.
- I develop a contraindication or serious side effect of the medication.
- I do not comply with medical requirements, i.e., visits, med doses, etc.
- I fail to lose and/or maintain weight appropriately.
- I have a planned surgery. Medications are to be stopped at least 2 weeks prior to any surgical procedure requiring general anesthesia.

Women Only: I understand Phentermine should not be taken during pregnancy, due to the chance of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both Perspective Health and my OB/GYN immediately. In addition, Phentermine is not to be used while breastfeeding.

NO GUARANTEE: 1) UNDERSTAND THAT MUCH OF THE SUCCESS OF THE PROGRAM WILL DEPEND ON MY EFFORT, AND THAT THERE IS NO GUARANTEE THAT THE PROGRAM WILL BE SUCCESSFUL. 2) I UNDERSTAND THAT AN INDIVIDUAL WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL MY LIFE, IF I AM TO BE SUCCESSFUL LONG-TERM.

Patient Consent/Waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of the risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release Tammy Chesley, FNP-C, Rebecca Lucas, FNP-C, and Perspective Health from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment. I understand it is my responsibility to give the name of my primary care physician where labs and/or EKG can be obtained for follow through and interpretation, if need be.

WARNING: If you have any questions as to the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask Tammy Chesley FNP-C or Rebecca Lucas, FNP-C now before signing this consent form. To conclude, by signing this document you are agreeing to the risks associated with Phentermine. You are agreeing that to be successful in your weight loss goals you must alter your lifestyle and adopt healthy eating and exercise patterns. You are agreeing that you are not pregnant or breastfeeding. You are agreeing that you understand Phentermine may be addictive. You are agreeing that you must notify Perspective Health of any medical conditions current or that develop while taking Phentermine and you are agreeing that this document has been adequately explained to you and that you understand the document in its entirety.

I understand the risks associated with taking Phentermine and agree to take only as prescribed and report any adverse reactions immediately.

Name: _____

Signature: _____ Date: _____

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HIPAA – Notice of Privacy Practices

Perspective Health is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Summary of Rights and Obligations Concerning Health Information

Perspective Health is committed to preserving the privacy and confidentiality of your health information which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Perspective Health. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- Plan your care and treatment;
- Provide treatment by us or others;
- Communicate with other providers such as referring physicians;
- Receive payment from you;
- Make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- Make you aware of services and treatments that may be of interest to you; and
- Comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have the right to:

- Ensure the accuracy of your health record;
- Request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
- Request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- Maintain the privacy of your health information;
- Provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of our most current *Notice of Privacy Practices*;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Disclosure of Your Health Care Information:

We may disclose your healthcare information as necessary to comply with State Workers Compensation laws, Public Health Authorities, Emergency Situations, Judicial & Administrative Proceedings, Law Enforcement, Medical Examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude for referrals, and change of ownership.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Name: _____

Signature: _____ Date: _____

Perspective Health

Tammy Chesley, FNP-C Rebecca Lucas, FNP-C
3530 S Val Vista Dr. Suite A111
Gilbert, AZ 85297

Consent for Telehealth

This consent is for all telehealth services provided to me by Perspective Health. Please select the provider you are scheduled with today:

☐ Tammy Chesley, FNP-C

☐ Rebecca Lucas, FNP-C

Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators.
Specifically, a health care professional will be communications with me remotely via the Internet using doxy.me web-based audio-video software (referred to in this form as Telehealth Appointment).
Doxy.me only hosts the software and does not provide medical advice or information.
This Telehealth Appointment may be for diagnosis, continuity of care, treatment, testing, or medical consultation deemed necessary by my Healthcare Provider or me.

I understand that during a Telehealth Appointment

- Details of my medical history and personal health information may be discussed with me and/or other health professionals
- Audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record
- All confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment
- Industry standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption
- There may be security and privacy risks associated with Internet-based communications
- There are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider.
- Either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate for diagnostic decision-making or for providing the care I desire.
- In addition to my Healthcare Provider named above, I will be informed of any other person who may be present during the appointment and have the right to have them leave the viewing and listening area.
- To maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment
- Due to the limitations of telehealth that are out of my control (such as an unreliable Internet connection), I will call local authorities (9-1-1) to assist me with a medical emergency
- I have the right to omit or withhold specific details of my medical history/physical examination

that are personally sensitive
- My Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me
- The communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider

Therefore, by consenting to this Telehealth Appointment:

- I desire to engage in remote audio-visual communication with my Healthcare Provider
- I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed
- I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
- I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment
- I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider
- I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy
- If my questions are not answered to my satisfaction, I have the right to terminate the appointment
- I am at least 18 years of age

Name: _____

Signature: _____

Date: _____

Name:	**DOB:**	**Today's Date:**

DIET AND LIFESTYLE

Exercise	☐ Sedentary (no exercise)
	☐ Mild exercise (doesn't require increased breathing or sweating)
	☐ Occasional exercise (regular exercise 1-3 times per week)
	☐ Regular exercise (consistent regimen)
Diet	Do you follow a specific diet? ☐ Yes ☐ No If yes, please indicate: ☐ Vegan ☐ Vegetarian ☐ Other (please list): How many meals do you eat in an average day? _____

WEIGHT LOSS

What is your **current** weight? _____ What is your height? _____ft _____in

What is your **highest** weight? _____

What is your **lowest** weight? _____

What is your **goal** weight? _____

When did you first become overweight?

How did your weight gain start?

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

Have you ever stayed the same weight for 10 years or more? ☐ Yes ☐ No

Name:	DOB:	Today's Date:

CONTRIBUTING FACTORS
Please check all boxes that apply to your weight gain

- ☐ 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

PRIOR ATTEMPTS

What was your most successful strategy for weight loss?

How much weight did you lose with that strategy?

How quickly did you regain the weight?

RESTFULNESS

Do you have problems falling or staying asleep?	☐ Yes	☐ No
How many hours a night do you sleep?		
Do you wake up feeling refreshed?	☐ Yes	☐ No
Do you have a low energy level?	☐ Yes	☐ No
Does your energy level affect your daily activities?	☐ Yes	☐ No

Perspective Health
Tammy Chesley, FNP Rebecca Lucas, FNP
3530 S Val Vista Dr. Suite A-111
Gilbert, AZ 85297

Women's Hormone Questionnaire

Are you experiencing...	No	Occasionally	Frequently
Hot Flushes of Flashes	☐	☐	☐
Night Sweats	☐	☐	☐
Sweating	☐	☐	☐
Dissatisfied with my personal life	☐	☐	☐
Feeling anxious or nervous	☐	☐	☐
Poor Memory	☐	☐	☐
Accomplishing less than I used to	☐	☐	☐
Feeling depressed, down, or blue	☐	☐	☐
Being impatient with other people	☐	☐	☐
Feeling of wanting to be alone	☐	☐	☐
Flatulence or gas pain	☐	☐	☐
Aching in muscles or joints	☐	☐	☐
Feeling tired or worn out	☐	☐	☐
Difficulty sleeping	☐	☐	☐
Aches behind neck or head	☐	☐	☐
Decreased physical strength	☐	☐	☐
Decreased stamina	☐	☐	☐
Lack of energy	☐	☐	☐
Dry skin	☐	☐	☐
Facial hair	☐	☐	☐
Bloating	☐	☐	☐
Frequent urination	☐	☐	☐
Incontinence (involuntary urination)	☐	☐	☐
Decreased sexual desire	☐	☐	☐
Avoiding intimacy	☐	☐	☐
Painful intercourse	☐	☐	☐

Name: _____

Signature: _____ Date: _____