INSTITUTE of ENDOCRINOLOGY
Diabetes, Health & Hormones

Wellness Program

The "Wellness Program" offers office visits that solely focus on weight loss. The program is $79. We do not bill insurance for this program.

The payment includes weighing in with the provider and receiving most prescribed weight loss medication. Samples are available as a courtesy. The program also offers an $18 lipotropic injection (optional each visit) that is consistent of (6) different vitamins:

- Vitamin B12: Serves many biological purposes including normal blood, brain, heart, and nervous system functions; most importantly, it is essential for fat metabolism.
- B-Complex Vitamins: Increase energy and promote fat metabolism.
- Choline: An essential nutrient for proper liver function, choline detoxifies the liver by removing fat and bile and ensures fat is burned for energy.
- Inositol: Related to the B-vitamins, inositol is involved in the breakdown of fats, is used in various biological functions that can improve psychiatric conditions, and can be used as an effective treatment for PCOS and other female conditions.
- Methionine: An essential amino acid that defends the body against toxic compounds; also works as a deactivating agent to many hormones (including estrogen) and sulfur-containing compounds
- Amino acids such as Glutamine, L-Arginine, and L-Carnitine: Vital to multiple important biological roles in the body, enable other compounds to function correctly to stimulate weight loss

You can receive this injection here in our office every two weeks or once a month (no apt necessary).

WELLNESS PATIENT INFORMATION PACKET

Today's Date: _____

Name: _____ DOB: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____

City: _____ FL: _____ Zip: _____

Race:

- ☐ White
- ☐ Black
- ☐ Other: _____

Gender:

- ☐ Male
- ☐ Female

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Other: _____

Email: _____

Emergency Contact Name: _____

Phone Number: _____

_____

(Patient/Legal Guardian Signature)

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WEIGHT LOSS QUESTIONNAIRE

Name: _____ DOB: _____ Today's Date: _____
Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

What medical conditions, if any, do you have?

_____

_____

Have you had any surgeries? Please list them.

_____

_____

Do you have any allergies? Please list them.

_____

_____

What are your goals for weight control and management?

_____

_____

What is the hardest part about managing your weight?

_____

_____

What do you believe will be the most help to assist you in losing weight?

_____

_____

WEIGHT HISTORY

If you recall, what was your body weight at each of the following times?
Grade school _____ High School _____ College _____ Age 20-29 _____ Age 30-39 _____
Age 40-49 _____ Age 50-59 _____
What has been your lowest body weight as an adult? _____ Heaviest as an adult? _____
At what age did you start trying to lose weight? _____
What programs have you recently tried in order to lose weight? Include dates and length of participation:

Program	Date	Weight	Duration	Medication	Exercises	Surgeries	Diet/Nutrition

Have you maintained any weight loss for up to 1 year on any of these programs? If so, which one?

_____

_____

If you have been involved in physical activities to help you lose weight, which physical activity helped you lose the most?

_____

_____

What medications helped you the most, if any in the past?

_____

_____

How confident are you that you can lose weight at this time? (1 = Not Confident – 5= Very Confident)
1 2 3 4 5
What is your level of interest in losing weight? (1 = Not Interested – 5 = Very Interested)
1 2 3 4 5
Are you ready for a lifestyle change to be part of your weight control program? (1 = Not Ready – 5 = Ready)
1 2 3 4 5
How much support can/will your family provide? (1 = No Support – 5 = A Lot of Support)
1 2 3 4 5
How much support can/will your friends provide? (1 = No Support – 5 = A Lot of Support)
1 2 3 4 5

MEDICATION LIST

Name of medication	Dosage	How Often

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WEIGHT LOSS PROGRAM CONSENT FORM

I _____ authorize Dr. Kamel and The Institute of Endocrinology, and whomever they designate as their assistants to help me in my weight reduction effort. I understand that results may vary from one person to another, and I understand that much of the success of the program will depend on my efforts and that there are no guarantees of assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I may be asked to be evaluated by a Nutritionist and consider their recommendations. I may also be asked to meet with a personal trainer. I may also be asked to start a physical exercise program that is designed especially for my needs. I may be asked to have some cardiopulmonary testing or in some cases to be evaluated by a cardiologist prior to starting such an exercise program to be medically cleared.

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, such as arthritis, chronic pain, joint pain, chronic fatigue, diabetes, and variable diabetes. These risks can increase in severity the longer I am overweight and the more overweight I become. These and other possible risks could, on occasion, be serious or even fatal.

Treatment options provided by my doctor and his staff may include a balanced deficit diet, a regular exercise program, instruction in behavior modification-techniques, and may involve the use of appetite suppressants and weight loss medications. Other treatment p0lans may also include, but not limited to, a low-calorie diet, low carbohydrate diet, and/or a high protein diet and/or a protein supplemented diet.

I understand I may be asked by the doctor and his staff to take prescription medications. These prescription medications may or may not be covered by my insurance. I am liable for the costs of my prescription drugs whether they are covered by insurance or not. If appetite suppressants are used, they sometimes may be used for durations exceeding those recommended in the medication package insert. They may also be used outside of the recommended body max index or off label. It has been explained to me that these medications have been used safely and successfully in private medical practices, as well as in academic centers, for periods exceeding those recommended in the product literature.

Risks of this program with the use of prescription medications may include, but are not limited to, weight loss, suppressed appetite, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances such as nausea, vomiting, diarrhea, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, chest pain, syncope, and other heart irregularities. These and other possible risks could, on occasion, be serious or fatal.

WEIGHT LOSS PROGRAM CONSENT FORM (Cont.)

I understand that much of the success of the program will depend on my efforts, such as my level of determination, dedication, and motivation. I may also be asked to see a counselor to help develop and recognize these characteristics that I have.

I have fully read and 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 I have any questions regarding the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, I will ask my doctor now before signing this consent form.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

WEIGHT LOSS PROGRAM CUSTOMER BILL OF RIGHTS

WARNING

- Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1.5 - 2 pounds per week or weight loss of more than 1 % of body weight per week after the second week of participation in a weight loss program.
- Consult only your physician before starting any weight loss medic action.
- Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long term weight loss.
- Qualifications of this provider are available upon request.
- You have the right to ask questions about potential health risks of this program and its nutritional content, psychological support, and educational components.
- You have a right to receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
- You have the right to know the actual or estimated duration of the program.
- You have the right to know the name, address, and qualifications of the dietitian or nutritionist who has reviewed and approved the weight loss program according to Section 468-505(1) Florida Statutes.

Required to be posted by Section 501.0575 of Florida Statutes

I have read the above statements.

- ☐ Yes
- ☐ No

Patient's Name: _____ Date: _____

Patient's Signature: _____

URINE DRUG TEST CONSENT

As a part of our Wellness Program, you will be subjected to an initial urine drug test and a random drug test thereafter. We are drug screening for illegal drugs and the results of the test are confidential. A positive test result could result in dismissal from our Wellness Program.

I hereby agree to submit to a drug test by furnishing a sample of my urine for analysis. I have been fully informed of the reason for this test and understand what I am being tested for and the procedure involved. I am fully aware that the results of this test will be added to my medical file.

I understand that if at any time I refuse to submit to a drug test, or if I otherwise fail to cooperate with the testing procedures, my involvement with the Wellness Program will be dismissed.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Controlled Substance Consent and Contract

I _____, understand that I have been prescribed a controlled medicine. Controlled substance medications are useful for certain medical clinical conditions. However, controlled medications have high potential for misuse and are therefore closely monitored and controlled by local, state, and federal government agencies.

I fully understand the need for controlled substance medication for my case. I was given the chance to ask questions and receive explanations about my diagnosis. I was also given information about the possible side effects and possible habit forming and psychological dependence of controlled substance medications. Alternative treatments and other options were discussed with me.

I agree to comply with the following:

1. I am responsible for the control substance medication prescribed and the prescription given to me. If my prescription is misplaced, stolen, or if I run out early, I understand that this medication will not be replaced regardless of the circumstance.
2. Initial prescription and refills of controlled substance medication must be given only during office visits and will not be called in by phone or sent electronically.
3. Any controlled medication that is class II or III will only be prescribed for 1 month at a time. The patient must be re-evaluated every month for the continued need of the medication.
4. I agree to comply with urine testing and pill counts when I am asked to do so. I understand that this is necessary to document the proper use of this medication.
5. I agree not to seek prescriptions for the same medication I am given here from another physician or clinic while I am in the wellness program.
6. I understand that I must inform the clinic about any medication I am taking, including any controlled substance medication.
7. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the use of nonprescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacists, medical facilities, and the appropriate authorities.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

633 E Baldwin Rd. Panama City FL 32405 Phone 850-522-5490 Fax 850-215-5987

TENUATE CONSENT FORM

I _____, would like to be prescribed Tenuate for weight loss purposes.

The medical provider has explained to me all the risks and benefits associated with the use of the medications including the risk of developing pulmonary hypertension and the habit-forming risk involved. I was provided with a printout, from up to date, that explains to me the risks as well.

The medical provider has explained to me that there is a lack of scientific data regarding the potential danger of long-term use of combination weight loss treatments.

The medical provider has clearly explained to me that following a healthy diet and physical exercise are a must for any weight loss regimen.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

633 E Baldwin Rd. Panama City FL 32405 Phone 850-522-5490 Fax 850-215-5987

ADIPEX CONSENT FORM

I _____, would like to be prescribed Adipex for weight loss purposes.

The medical provider has explained to me all the risks and benefits associated with the use of the medications including the risk of developing pulmonary hypertension and the habit-forming risk involved. I was provided with a printout, from up to date, that explains to me the risks as well.

The medical provider has explained to me that there is a lack of scientific data regarding the potential danger of long-term use of combination weight loss treatments.

The medical provider has clearly explained to me that following a healthy diet and physical exercise are a must for any weight loss regimen.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

INSTITUTE of ENDOCRINOLOGY
Diabetes, Health & Hormones

Consent for compounded Semaglutide, compounded Tirzepatide, compounded Liraglutide, compounded Dulaglutide, and compounded Pramlintide in injectable and sublingual forms.

By signing this consent, I agree to use one or more of the above-listed compounded medications for weight loss and/or diabetes treatment.

I understand that these medications are compounded by a compounding pharmacy, which is not under the oversight of the FDA but follows pharmacy compounding standards.

The listed compounded medications are typically used to treat obesity and type 2 diabetes. They could be similar to commercially available medications which are present under several brand names such as Victoza/Saxenda, Ozempic/Wegovy, and Mounjaro/Zepbound, but they were not compared head-to-head.

Potential side effects of the above-listed medications may include nausea, vomiting, and other gastric issues. I have received the UpToDate patient information packet on these medications, including potential side effects. I accept all potential benefits and risks.

I do not have a personal or family history of Medullary thyroid carcinoma, a personal history of pancreatitis, and do not currently have gallstones or diabetic retinopathy.

I have chosen compounded medications over the commercially available similar ones; I understand the differences and had the opportunity to ask questions and discuss any concerns. I have been given ample time to ask questions, and all have been answered.

Name: _____ Signature: _____

Date: _____

DOB: _____

INSTITUTE of ENDOCRINOLOGY
Diabetes, Health & Hormones

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THE LIPOTONIX PLUS #10B INFORMED CONSENT

This informed consent form is intended to:

1) Give fair notice of requirements of patients seeking to participate in the Lipotropic (M.J.C.) Injection or B-12 Injection or a combination of both (Lipotropic and B-12) Injections as part of a weight loss program.
2) Fully disclose any risks associated with participation in the Lipotropic (M.J.C.) Injection or B-12 Injection or a combination of both (Lipotropic and B-12) Injections as part of a weight loss program.
3) Obtain written "Informed Consent" from the patient to undergo treatment by healthcare professionals associated with The Institute of Endocrinology, Diabetes, Health, and Hormones.

I understand that I am voluntarily participating in a weight loss program involving behavioral modification, dieting, and bi-weekly or monthly Lipotropic (M.J.C.) Injection or B-12 Injection or a combination of both (Lipotropic and B-12) Injections.

I understand the results are not guaranteed, may vary, and that it is necessary for me to follow the required diet plan in conjunction with Lipotropic (M.J.C.) Injection or B-12 Injection or a combination of both (Lipotropic and B-12) Injections to achieve my desired weight loss goal.

I have been informed of our billing requirements and our financial policy. I understand that payment for all services will be due at the time services are rendered.

I understand that the Wellness Program is a "cash practice" therefore, my insurance will not necessarily cover any procedure or payment towards my sessions.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand there are no refunds once services have been provided. I further agree in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees, should this be required. 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 fees, and court costs.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

INSTITUTE of ENDOCRINOLOGY
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633 E Baldwin Rd. Panama City FL 32405 Phone 850-522-5490 Fax 850-215-5987

THE LIPOTONIX PLUS #10B INFORMED CONSENT

I have been informed of the following:

Vitamin B-12 helps maintain good health and has been shown to be beneficial in helping to: Reduce stress, fatigue, improve memory and cardiovascular health, and maintain a good body weight. It can also assist the body in converting proteins, fats, and carbohydrates into energy and is necessary for healthy skin and eyes.

B-12 injections are better absorbed by the body since they go directly into the bloodstream. Alternatives to B-12 injections or oral vitamins, B-12 Patch, Lozenges, Liquid drops, and nasal spray.

B-12 injections common side effects include, but are not limited to:

- Risks: I understand there is a risk of mild diarrhea, upset stomach, nausea, a feeling of pain and warm sensations at the site of injection, a feeling or sense of being swollen over the entire body, headache, and joint pain.
- If any of these side effects become severe or troublesome, I will contact my physician immediately.
- I understand that although rare, Vitamin B-12 injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking Vitamin B-12 injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of B-12 injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects may include:
  - Rapid heartbeat
  - Chest pain
  - Flushed face
  - Muscle cramps and weakness
  - Difficulty breathing and swallowing
  - Dizziness
  - Confusion
  - Rapid weight gain
  - Tight feeling in the chest
  - Hives, skin rashes
  - Shortness of breath when there is no physical exertion and unusual wheezing and coughing
- Before starting Vitamin B-12 injections, I will make sure to tell my physician if I am pregnant, lactating, or have any of the following conditions:
  - Leber's disease
  - Kidney disease
  - Liver disease
  - Iron deficiency
  - Folic Acid deficiency
  - An infection
  - Receiving any treatment that has an effect on bone marrow
  - Taking any medication that has an effect on bone marrow
  - An allergy to Cobalt or any other medication, vitamin, dye, food, or preservative.
- I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non-prescription medication may result in side effects when they interact with the B-12 injection.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

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THE LIPOTONIX PLUS #10B INFORMED CONSENT

I have been informed of the following:

- While the components generally have no side effects, doses much be taken at regular intervals. The injections are only effective temporarily. As soon as the effect of these drugs wear out, the body starts returning to normal.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people have experienced allergic reactions to injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys. Some patients have been unable to control \their urine and/or had diarrhea.
- Depression is another possible side effect.
- It has been reported that B-12 can cause peripheral vascular thrombosis, itching, and a feeling of swelling in the body.
- Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pain.
- Lipotropic Injections change the function of the digestive system temporarily. This can result in extreme exhaustion.
- Weight loss can be inconsistent from one week to the next. there can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have side effects of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.
- Vitamin B-12 is contradicted in Leber's Hereditary Optic Neuritis, as it can cause blindness.

I will inform my provider of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

I have read the above and I agree to accept the risk of the procedure. All my questions have been answered with satisfaction. I agree to release the facility and the medical practitioner from any liability arising from the procedure. I consent solely to arbitration as a legal means of settlement.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

INSTITUTE of ENDOCRINOLOGY
Diabetes, Health & Hormones

BILLING POLICIES

Our goal is to provide an maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

On arrival, please sign in at the front desk and present your current insurance card. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf.

IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurance at the time of the visit. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
3. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
6. If previous arrangements have not been made with our finance office, any balance over 60 days will be forwarded to a collection agency.
7. A $20.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
8. It is your responsibility to know if a selected specialist participates in your plan.
9. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
10. You agree to pay a **$75.00 No-show fee** if you do not show up for your appointment and did not call to cancel or reschedule at least 24 hours prior to your appointment.

Patient Name _____

_____ _____

Responsible Party Member's Name Relationship

_____ _____

Responsible Party Member's Signature Date

INSTITUTE of ENDOCRINOLOGY
Diabetes, Health & Hormones

Medical Release Consent Form for Wellness Medication Pick-Up

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____

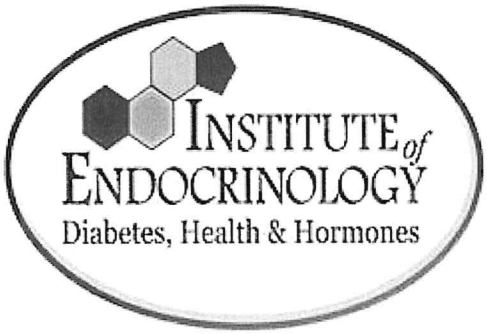
I, hereby authorize the individual(s) named below to pick up prescription medications on my behalf:

- **Authorized Person's Name:** _____
- **Relationship to Patient:** _____

- **Authorized Person's Name:** _____
- **Relationship to Patient:** _____

I understand that by signing this form, I authorize the above-named individual(s) to pick up my prescription medications. I understand that this person may be asked to provide identification and that the office may release information regarding my prescription(s) as necessary for the pick-up process.

Patient Signature: _____ **Date:** _____



Today's Date: _____

Patient's Name: _____

Patient's DOB: _____

Advance Directives:

Do you have written advance directives?

_____ Yes

_____ No

_____ I am unsure

Code Status:

In the unexpected and rare case of a code (heart or respiration stops), what option would you prefer?

_____ Full code, including doing chest compression and cardiac shock if needed.

_____ Do not resuscitate, meaning no cardiac shocks or assisted breathing
(If you select this option, you must fill out a DNR form)

_____ I have not decided at this time.

_____

Patient/ Guardian's signature