LIFESTYLE MEDLY
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CONSENT FOR TELEHEALTH SERVICES

I, _____, am a patient at Lifestyle Medley, LLP (the "Practice"). I acknowledge that my provider_____has offered me Telehealth services. As evidenced by my signature at the end of this form and by my initials next to each statement below, I acknowledge and agree as follows:

I am signing this Consent Form to express my wish to receive healthcare services, including but not limited to, the prescription/utilization of Semaglutide or Terzepatide for weight loss ("Services"), via Telehealth, as set forth below, and to express my understanding and acknowledgment of the risks and benefits associated with Telehealth, and the alternatives to Telehealth. _____

I understand that "Telehealth" means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. I understand that the purpose of Telehealth is to support and facilitate the provision of health care services to patients. _____

I understand that I will not be in the same location or in the same room (i.e., at the same "site") as my provider during Telehealth consultations. _____

I understand that my provider may be a licensed physician, registered nurse, nurse practitioner, physician assistant, or other health care professional acting within the scope of a valid license or certification under New Jersey state law. _____

I understand that I may specifically request that my Telehealth encounter be scheduled with a physician, and if so, the Practice shall schedule my Telehealth encounter with a physician. _____

I understand that the potential risks of Telehealth, despite reasonable efforts on the part of the Practice, include limitations on performing comprehensive physical examinations, technical difficulties/interruptions/disruptions of service, inaccuracy of data transmission, and vulnerability to privacy and security breaches. _____

I understand that alternatives to Telehealth include an in-person visit with my provider at his/her physical office location, or an in-person visit with another provider of my choice. _____

I understand that potential benefits of Telehealth include comfort, convenience, improved access to medical care, reduction of travel and wait times, efficient medical evaluation and management, reduced exposure to illness (i.e., patients, medical staff, and other individuals at my provider's physical location), and increased patient satisfaction. _____

I understand that the identity, professional credentials and contact information of the Practice's provider from whom I receive Telehealth services ("Treating Provider") will be made available to me (i) at the time I schedule services to be provided using Telehealth, if available, or (ii) upon confirmation of the scheduled Telehealth encounter, and (iii) during and after the provision of Telehealth services. I further understand that that contact information will enable me to contact my Treating Provider or a substitute provider on behalf of the Treating Provider, for at least 72 hours following the Telehealth encounter. _____

I understand that I have the right to request my medical record, including information obtained during Telehealth encounters, and to request that my medical record be forwarded directly to my primary care provider, healthcare provider of record, or any other health care provider specified by me, with my consent, which may be oral, written or digital in nature, at a cost borne by me in accordance with law. _____

I understand that any health care provider providing healthcare services using Telehealth (diagnosis, treatment, and consultation recommendations, including the risks and benefits of my treatment options and the issuance of prescriptions based on my Telehealth encounter) is subject to the same standard of care and practice standards applicable to in-person settings. I further understand that my provider may direct me to seek an additional in-person medical evaluation if the provision of Telehealth services would not be consistent with the standard of care. _____

I understand that I may discuss the risks and benefits of Telehealth with my Treating Provider, and ask questions about Telehealth services. I further understand that I may, in a writing to the Practice, withdraw this Consent to receive Telehealth services, or end a Telehealth encounter at any time, without affecting my right to future care or treatment. _____

I hereby acknowledge that the Practice has notified me, prior to providing Telehealth services, of the risks and benefits of being treated through Telehealth, and how to receive follow-up care or assistance (i) in the event of an adverse reaction to any treatment I receive on the basis of Telehealth services, or (ii) in the event of an inability to communicate as a result of a technological or equipment failure. _____

I have received notice of the Practice's written privacy practices prior to receiving Telehealth services, and have provided my written acknowledgement of the same. _____

I acknowledge that I have had the opportunity to ask questions of my provider, and all questions and concerns related to the provision of Telehealth have been satisfactorily answered by my provider. _____

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By my signature below, I declare my consent to receive Telehealth services, described herein.

_____

PATIENT NAME (print)

_____ _____

SIGNATURE DATE

CONSENT TO TIRZEPATIDE/SEMAGLUTIDE FOR WEIGHT LOSS

I, _____, am a patient at Lifestyle Medley, LLP (the "Practice"). I acknowledge that my provider _____ has offered me a treatment option involving the prescription/utilization of Terzepatide or Semaglutide for weight loss. As evidenced by my signature at the end of this form and by my initials next to each statement below, I acknowledge and agree as follows:

I am signing this Consent Form to authorize the Practice to administer patient care services ("Services"), as set forth below, and to express my understanding and acknowledgment of the risks and complications associated with, and that may arise from, each such service. _____

I understand that the Services include the prescription and utilization of the medication (i) Terzepatide; or (ii) Semaglutide. Both medications are designed to decrease appetite and facilitate weight reduction for adults with obesity, excess weight or weight-related medical problems, and are used in conjunction with monitoring, diet, exercise, and other care recommended by my provider, and both medications are administered via injection . _____

I understand and agree that certain of the Practice's Services may not be reimbursable to me, or to the Practice, as "Covered Services" as defined by my insurance carrier, and that if such Services are not Covered Services, I am responsible for all costs associated with my treatment at Practice. I understand that the financial responsibility for the Services rests upon me, and I commit to meeting any financial obligations as stipulated by the Practice before commencing the treatment.

_____

I understand that there is currently (as of the date hereof) a shortage of Terzepatide and Semaglutide per the Food and Drug Administration ("FDA"), and both medications are currently listed in the FDA's Drug Shortages Database. I understand that, under federal law, when there is a drug shortage, the FDA considers the drug "not commercially available," and permits compounding pharmacies to compound such drug in order to make it accessible to patents. I further understand that, should Tirzepatide or Semaglutide be removed from the FDA's shortage list, I may no longer be able to obtain Tirzepatide or Semaglutide ("Injectables"), as applicable, from a compounding pharmacy, except under limited circumstances, which may significantly change the price of the medication. _____

I acknowledge and understand that the compounding pharmacy selected by me or utilized by the Practice to compound the Injectables is solely responsible for the compounding services it provides, including but not limited to, operating and compounding in compliance with (i) the compounding law set forth in Section 503A of the Federal Food, Drug and Cosmetic Act (the "Act"); (ii) all rules and exceptions set forth in the Act and applicable FDA regulations pertaining

to compounding; and (iii) state laws and regulations governing sterile compounding and prohibitions on compounding. _____

I acknowledge and understand that the compounding pharmacy selected by me or utilized by the Practice to compound the Injectables is solely responsible and liable for any errors in compounding the Injectables, for any improper, prohibited or negligent compounding that occurs at the pharmacy in violation of federal or state law, and for any adverse reactions experienced by me in connection therewith. Further, the Practice makes *no claims, representations or warranties, whether express or implied, as to the safety or reliability of the Injectables, and the Practice accepts no liability whatsoever* for any damages or any other loss which I may suffer, arising from any defect of the Injectables, or arising from my use or misuse of the Injectables. _____

I acknowledge and understand that in accordance with FDA Policy Sec. 460.300, I cannot return the Injectables once the medications/injections leave the dispensing pharmacy. I further understand that under no circumstances will I be eligible for a refund from the Practice or the pharmacy for the costs associated with Services. _____

I acknowledge and fully understand that there are many possible benefits I may derive from the Injectables, including reducing my appetite and food intake, weight loss, and improvements in BMI, lipid levels, diabetes indicators and blood pressure. _____

I acknowledge and fully understand that there are many potential known risks, complications and side effects that may arise as a result if the services I am receiving, including, without limitation: (1) nausea; (2) vomiting; (3) diarrhea; (4) constipation; (5) abdominal discomfort; and (6) potential fluctuations in blood sugar levels. Less common risks and complications include: (1) heartburn; (2) fever; (3) stomach pain/discomfort; and (4) yellow eyes or skin. Severe side effects may include: (1) vision changes; (2) pancreatitis; (3) kidney failure; (4) gallbladder issues; and (5) allergic reactions. _____

With all Injectables, patients may experience a slight burning sensation while the solution is injected, and/or redness, itching or swelling at the injection site. _____

I acknowledge that I have been offered the opportunity to receive injections at the Practice, should I choose not to self-administer the Injectables, and that in-office injections may be administered by non-physician practitioner staff at the Practice. _____

I acknowledge and fully understand the alternatives to Injectables include no treatment, a reduced-calorie diet, increased physical activity, other weight loss medications, behavior modifications, and surgery. Risks and potential complications are also associated with alternative forms of medical or surgical treatment. _____

I acknowledge and fully understand that the Practice does not make any assurances or guarantees of success or precise amounts of weight loss, and that the Injectables alone may not produce an outcome that meets expectations for weight loss. I further understand that the success of the

Injectables for weight loss and my maintenance of any weight loss attained depends partly on my efforts. _____

I acknowledge and fully understand that Injectables may not be suitable for me if I (1) have endocrine tumors; (2) have eye disease, vision problems; (3) have gallbladder disease; (4) have a history of pancreatitis; (5) have kidney disease; (6) am prone to stomach or intestine problems; (7) thyroid cancer or a family member had thyroid cancer; (8) have allergies to either of the Injectables, or to other medications, foods, dyes or preservatives; (9) am pregnant or trying to get pregnant; or (10) am breastfeeding. _____

I acknowledge and fully understand that I have the responsibility to let my provider know whether I have any of the above conditions before the procedure. I further acknowledge that I have provided a comprehensive medical history, including details on allergies, medications, medical conditions, and prior attempts at weight loss, to optimize the success and safety of the therapy.

_____

I recognize that, during the administration of the Injectables, unforeseen conditions may necessitate different procedures than those listed above. I therefore authorize my provider or his/her associates, assistants or designees to perform such other procedures that are in the exercise of their professional judgment, necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my provider at the time the treatment begins. _____

I acknowledge and understand that my progress may be documented through photographs or videos for internal clinical records within the Practice. These visual records shall be treated with confidentiality and shall not be disclosed publicly without obtaining my explicit consent.

I assume full liability for any adverse effects, complications, unforeseen outcomes and personal injury that may result from the non-negligent provision of any Services. I hereby voluntarily, intelligently and knowingly forever release, waive, and discharge the Practice, and its present, former and future owners, managers, officers, directors, employees, independent contractors, agents, attorneys, insurers and representatives and their respective successors, heirs and assigns or any volunteers from any and all claims, actions, liability, injury, damages, losses, whether at law, in equity or pursuant to any contract, including, without limitation, breach of contract actions, breach of statutory duty or other duty of care actions, warranty actions, product liability, strict liability actions, malpractice actions, tort actions, and any other cause of action whatsoever that I now have or I might have in the future arising out, of or related to, any loss, damage, or injury, including, without limitation, death, or the development, deterioration, or worsened prognosis of any medical condition or disorder I may have, that I may sustain as a direct or indirect result of the Services provided to me by the Practice or anyone with which Practice is associated/affiliated.

_____

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I affirm my ability to read and comprehend English, fully grasping the contents of this consent form. _____

I hereby authorize my provider and such associates/assistants as may be selected, to treat me with the Injectable Terzepatide _____ Semaglutide _____, and I have been informed about the risks, benefits, and alternatives to the injections. _____

I acknowledge that I have had the opportunity to ask questions of my provider, and all questions and concerns related to the Injectables have been satisfactorily answered by my provider. _____

By my signature below, I declare my consent to undergo weight loss therapy utilizing the Injectables, described herein.

_____

PATIENT NAME (print)

_____ _____

SIGNATURE DATE

