DR. EDWARD E. DICKERSON, IV

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REJUVENATING MED SPA
FACIAL PLASTIC SURGERY

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, thalessemia, 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:**_____

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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 ☐ Scarlatina ☐ 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	☐ Joint pains	☐ Muscle aches
☐ Arthritis	☐ Limitation of motion	☐ Backache	☐ Leg pains	☐ Heel Pains
☐ Pain or stiffness (neck)		☐ Goiter	☐ Swelling, enlarged glands	
☐ Asthma	☐ Lung disease	☐ Raise sputum	☐ Emphysema Bronchitis	
☐ Heart trouble		☐ High blood pressure	☐ Shortness of breath	☐ Palpitation or fluttering ☐
Chest pain	☐ Lips or nails turn blue		☐ Tire easily	☐ 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		☐ Pus 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 ☐
Neuritis or Neuralgia		☐ 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:
_____

Do you currently have any medical concerns? Please List:

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

Submitting Office
Cape Fear Aesthetics
2053 Valleygate Drive
Suite 102
Fayetteville, NC 28304
Phone: (910) 323-3757 Fax: (910) 222-3068

Destination Lab
Phone: Fax:

Form # 12-0007

Patient ID:
Name:
Birth Date:

Date:
Gender:

Specimen Order Number: 12-0007 - A

Dx: Fatique 780.79
Overweight 278.02

To Be Ordered: Lipid Panel, Cortisol, DHEA, Prolactin, RPR, Estrogen, Ferritin, 17-OH Progesterone, ANA, Fe, Thryroid 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