Raven Weight Loss Clinic
701 Market St.
Suite 113
St. Augustine, FL 32095
(904) 852-1960

INFORMED PATIENT CONSENT

Dear Patient,

Today you will receive a consultation by a clinic staff member regarding our weight loss program. After you speak with the physician, he or she will decide whether or not you are a candidate for treatment with our GLP-1 medication for weight loss.

The medication is given subcutaneously weekly, and may have some side effects such as mild nausea or stomach cramping as you are adjusting to it. You will be provided some medication to combat the nausea. Some patients also experience indigestion, but this is usually mild and relieved with over the counter antacids. Persons with a family history of thyroid cancer or multiple endocrine neoplasia syndrome, or a history of pancreatitis will be precluded from being prescribed this medication.

I, _____, fully understand the nature of the medication described above and the possible side effects. I agree to pay a medical consultation fee of $_____ upon completion of my visit, and I am aware that purchases of any other medications I elect are final and nonrefundable. I understand I am enrolling in a weight loss program, but should the doctor not clear me medically to receive the treatment, my initial payment of $_____ will not be refunded, however, any payment beyond the initial consultation fee will be refunded in the manner it was paid. I understand my monthly participation fee, which covers my ongoing monitoring and my medication, will be charged automatically each month. I consent to treatment by Raven Weight Loss Clinic physician indicated below. I acknowledge that these services are considered to be elective treatments, and that they are not covered by Medicare or most other insurance providers. Any medications ordered by me are non-returnable in accordance with applicable laws

Signed this _____ day of _____, 20_____

Patient's Name Printed: _____ Patient Signature: _____

Witness Signature: _____