[Clinic name]

INFORMED CONSENT FOR CONSULATION

I, _____, give permission for **CMG Medicine/California Medical Group** to receive a consultation by a physician via telemedicine. The physician will decide whether I am a candidate for treatment with Compound Semaglutide medication for weight loss.

The medication is given subcutaneously weekly and may have some side effects such as mild nausea or stomach cramping as person adjust to it. 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 $**99** upon completion of my visit and $**99** for follow-up visits, thereafter. I also agree to $**75** cancelation/no show fee if you are unable to make your appointment without giving at least 24 hours prior notice. I understand I am enrolling in a weight loss program, but should the doctor not clear me medically to receive the treatment or I choose not to enroll in weight loss program, my initial payment of $**99** will not be refunded. I consent to treatment by **CMG Medicine/California Medical Group** 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.

I have read and understand the information provided by **[clinic name].**

_____

Patient's Signature

_____

Print Patient's Name

_____

Date

[address]
[city, state zip code]
[phone#]