[clinic name]

INFORMED CONSENT FOR MEDICATION ADMINISTRATION SERVICES
Compound Semaglutide *(enter complete prescription on vial)*

PATIENT INFORMATION

First Name_____ Middle Initial _____ Last Name _____

Date of Birth _____/_____ /_____ Sex/gender: o Male o Female

Address

Street _____

City _____State _____ Zip _____

Home/Mobile Phone _____

Driver License #_____

Prescriber for Administered Medication

[Clinic name]
[Doctor Name] [License#] [NPI#]
Office Phone Number: **[phone #]**

Payment Information

- ☐ **Monthly payment: $[price]**
- ☐ **Weekly payment: $[price]**
- ☐ ***(Add another payment plan, example…3 Months prepaid or Autopay monthly*): $[price]**

- ☐ Credit Card
- ☐ Care
- ☐ FSA/HSA
- ☐ Cash

Card #: _____
Expiration Date: _____
CSV#: _____

Automatic reoccurring monthly payment due every 4 weeks. If choose not to proceed after the first month, 30 day written cancel notice must be given.

Monthly payment, not reoccurring, requires a 10 -14 BUSINESS DAYS notice for refills. Client is responsible to contact office to avoid delays in refills and shipping.

[clinic name]

By my signature below, I consent to the administration of the prescribed medication by a **[Clinic Name],** where permitted by law, and to be contacted at the phone number provided above regarding this medication service. I also release the pharmacy **[Clinic Name]** and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this medication. I understand that

- I have voluntarily chosen to receive the medication.
- I am of legal age and authorized to execute this consent form.
- I will immediately alert the prescribing physician of any medical conditions which may adversely affect my personal health or effectiveness of the medication such as history of thyroid cancer, multiple, endocrine neoplasia syndrome, or pancreatitis.
- I have received education about potential side effects of the medication (such as nausea, vomiting, diarrhea, constipation, gastroparesis, acid reflux) when they may occur, and when and where I should seek treatment. I understand that if I experience any side effects, I am responsible for following up with my prescriber at my expense.
- I have had the opportunity to ask questions about the medication, and all my questions have been answered. I understand the benefits and risks of the medication. Results varies from person to person.
- I understand my responsibility to inform primary physician that you are taking medication, especially if I have diabetes, heart diseases, and any other prior health conditions.
- I understand dosing of medication. I am responsible for following up and discussing with prescribing physician/ **[clinic name]** regarding medication dosage.
- I understand that my receipt of this medication is subject to reporting, by the pharmacy or its business associate, to my primary care physician, the prescribing physician, and/ **[clinic name],** if required, and I authorize these disclosures.
- 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 understand my monthly payment fee's.
- I understand any medications ordered by me are non-returnable in accordance with applicable laws.
- I understand that I must give a 30-day written notice to cancel reoccurring automatic payment if I choose not to proceed after the first month.
- I understand that a copy of my medical records will be stored in a confidential manner.

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

Patient Signature _____

Print Name _____

Date _____