WALLA WALLA AESTHETICS
AND LASER SPA

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. Moullet and Ginny Moullet ARNP.

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. Moullet and Ginny Moullet ARNP 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. Moullet and Ginny Moullet ARNP can only prescribe hCG and medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as trying to get pregnant, pregnancy, 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 pregnancy and 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:

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I understand that use of hCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. Moullet or Ginny Moullet ARNP 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.
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. ####. 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. ####. at that time.
PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. ####. 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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