VITAG HEALTH LLC.
HCG WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request injections or sublingual formulation 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/sublingual formulation myself. I understand that 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. Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD can work in conjunction with, but cannot replace my regular primary care physicians such as general practitioner or other specialists in family medicine or internal medicine. I understand Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD can only prescribe HCG and medications 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, breast feeding, history of gallbladder disease, diabetes, autoimmune disease, HIV, heart disease, Liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder(anemia, thalassemia, 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 Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD and facility from any liability associated with this procedure. **Initials**:____

While HCG is generally free of negative side effects, there is a possibility of the following:

Ovarian Hyper-stimulation Syndrome which is 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, Over stimulation of the ovaries causing production of many (ova) 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, Hair loss, Prostate enlargement, Difficulty breathing and Collapse.

I understand HCG treatments may involve risks and other unknown risks: **Initials:____**

I understand that the use of HCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD if I am pregnant, if 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:____**

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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; I agree to release Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD 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 I need to contact Vida Sarkodie NP in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD **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 Vida Sarkodie in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD at that time. Photographs: I give permission for photographs of the treated areas to be used by Vida Sarkodie in collaboration with Dr. Pradip Shah, MD and Dr. Tammoima Gichana, PharmD 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.

Patient's name Printed:_____

Patient's Name Signed:_____ Date:_____

Printed Provider's:_____

Provider's Name Signed:_____ Date:_____

Do you have any medical concerns?

Please List:_____

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Financial Policy:

Thank you for selecting ViTag health LLC 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 payments for all services are 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.

Patients signature_____ Date_____

All statements on this 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_____