



Consent for B Fit Wellness Injections and Acknowledgement of Information Received

State law requires that before any injection is given we obtain your consent. This consent is confirmation that we have discussed the nature and purpose of the medications, and the program in its full entirety. Also, to confirm the Physician and staff have answered any questions you have. Consult with your doctor or pharmacist before starting this diet program. Please read over all the information carefully and if you do not understand, please ask.

1. I _____ (patient name), hereby authorize SenteBella MedSpa and their health team to follow me on the B Fit Lifestyle Program.
2. In general terms, the nature and purpose of the medication provided to you during this program (with the Physician’s discretion) are indicated in the management of the obesity in a regimen of weight reduction named primarily upon calorie restriction and physical exercise.
3. Some risks known to be associated with the medication are: (Adverse reactions) Headaches, dry mouth, difficulty sleeping, diarrhea, blurred vision, constipation, cramps, unpleasant taste, and increased urination.
4. Some of the more serious adverse restrictions include but are not limited to: Erratic heart rhythm, elevated blood pressure, primary pulmonary hypertension. (These side effects are rare but can occur).
5. _____(Initial) I do not have a Sulpha allergy.
6. _____ (Initial) I am currently not taking any other diet pills.

I hereby state that I have read and fully understand this consent. All questions about this program have been answered in a satisfactory manner. This consent is valid until revoked by me in writing.

Patient Name

Date

Patient Signature

Date

Staff Witness Signature

Date