VALOR HEALTH
WELLNESS & AESTHETICS

Tirzepatide Assisted Weight-Loss Program
Consent for Treatment

Today's Date: _____

Name: _____ DOB: _____

Home Address:_____

Phone: _____ Email: _____

By my signature below I do willingly request and consent to Tirzepatide or B-12 injections (if selected) by Valor Health, LLC. While proven successful in weight loss, I understand that there is no warrant or guarantee of results from using Tirzepatide weekly injections.

1. I understand that as part of this program I will be required to complete a Medical History and meet with a Medical Provider to determine my candidacy. I understand that initial blood tests may be required in order to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to immediately report any problems that might occur to Valor Health, LLC, as well as my Primary Physician during the treatment program.

2. I understand that there could be risks involved, as there are with all medications. Failure to comply with the dosage recommendation and dietary restrictions could alter the weight loss results.

3. I agree that I am, and will be, under the care of my primary medical provider for all other medical conditions.

4. I understand that treatments for weight loss are rarely covered by insurance companies. We do not accept or bill insurance for this program.

5. I understand that medication is ordered on a per patient basis and that I am to pay in advance for the full month of injections. At any point I can choose to discontinue the program.

6. I acknowledge that all statements provided on the Medical History Forms are true and accurate to the best of my knowledge and that my treatments will be based on the information provided herein and if I willingly withhold information, I accept full liability for any consequence that may arise therefrom.

7. I acknowledge that Tirzepatide is in high demand throughout the country and despite Valor Health having multiple U.S. based suppliers, it's possible that the medication may not be available.

8. TIRZEPATIDE CONTRAINDICATIONS: I UNDERSTAND THAT IF I HAVE ANY OF THE FOLLOWING I SHOULD NOT TAKE SEMAGLUTIDE INJECTIONS: diabetic retinopathy (a type of damage to the eye from diabetes), low blood sugar, decreased kidney function, pancreatitis, medullary thyroid cancer, multiple endocrine neoplasia type 2, family history of medullary thyroid carcinoma and/or kidney disease with likely reduction in kidney function.

9. I have read and understand all the above statements and conditions and have been informed of potential side effects and risks that may be associated with the use of Tirzepatide. I fully understand what I am signing and hereby request and consent to this weight-loss treatment.

Patient Signature: _____ Date:_____

Valor Health, LLC Provider Name: _____

Signature: _____ Date:_____