Fayetteville Plastic Surgery Specialists
Cape Fear Aesthetics Med Spa

Greetings,

This is your physician supervised HCG Weight loss introduction. This protocol has been designed for clients whose time is valuable and who expect results, 1-2 pound of fat loss a day. We are the only local facility and surgeon in our area that is certified by the International Association of Physicians for Aesthetic Medicine.

Our goal is to facilitate the reduction of Pound & Inches. Many of our patients have seen a reduction/treatment of hypertension, high cholesterol and diabetes. A free copy of the original Dr. Simeon's Pounds and Inches protocol has been provided. Modifications have been made for location and our practice. We will review these changes and welcome any of your questions.

Print out this Packet and follow the instructions below. Familiarizing yourself with the information will make your consultation more efficient.

Thank you for your trust,

Edward E. Dickerson, IV, MD
Medical Director

Steps for success

1. **Make a decision!** This is not a diet. This is a selfish, stingy, regimented protocol that will reset your metabolism and help adjust your lifestyle.
    a. *Do not try to get smarter that the protocol.*
    b. *This is not a calorie counting exercise.*
2. **Write down your personal statement with a dry erase marker on your bathroom mirror.** It should begin with "I want... or I don't want..." Read it out loud to yourself when you wake up and when you go to sleep at night. This is NOT optional. Some examples:
    a. *"I want to fit in to a size ..."*
    b. *"I don't want to have to take a blood pressure pill!"*
3. **Download My Diet Coach- Weight Loss Motivation & Tracker- app on your Smartphone.** This tool helps facilitate our protocol. It will be like having my consultants at your disposal 24/7. *Skip this step if you do not have a smartphone.*
    a. The app is free. Type in My Diet Coach, and look for the logo of a pink mannequin, by InspiredApps.

b. You must study the App!
c. Open the app.
    i. Follow the initial steps, and click on the menu tab.
    ii. Go to Contact & FAQ
d. Here you will find helpful tips on navigating the app.
e. An Audio Pounds and Inches guide is available at this link. You may listen to or read the original protocol by Dr. Simeon.

4. **Fill out Intake form and Consent Form**
    a. Please initial and sign each page where requested.
5. **Quickly acquire your pre-protocol diagnostic evaluations/Labs**
    a. Historically in our practice the medical evaluation for overweight treatment options has been covered by insurance carriers (see your plan for details).
    b. Tricare participants can have labs drawn by their Primary Care Provider.
    c. Please have available your insurance card if you go to LabCorps, Quest diagnostic Centers, Primary care provider etc.
    d. Blood Work: we will provide an order set for required lab work (see below)
    e. EKG: a copy within 2 years from your primary care manager will do.
    f. Female Clients
        i. Pap Smear- a copy within 2 years from your primary care manager will do.
        ii. Mammogram (clients >35yrs old) - a copy within 2 years from your primary care manager will do.
6. If you are having problems acquiring these please contact us 910-323-3757 or info@capefearaesthetics.com. Don't let this delay your protocol.
7. **Deliver Intake Form/Consent Form/Pre-protocol evaluation to office.**
    a. Fax: 910-222-3068 (Attn: Physician Supervised HCG Weight Loss)
    b. Mail or drop off: CFA: Physician Supervised HCG Weight Loss, 2053 Valleygate Dr. #102 Fayetteville, NC 28304
8. **Invite a Friend.**
    a. If you have someone to help you be accountable that is GREAT for both of you.
9. **Book your Personal Consult**
    a. Call 910-323-3757 for your personal consult to begin your weight loss.

10. **Stay Social**
    a. Follow us on Social Media
       fayplasticsurgery.cfamedspa - Instagram
       https://www.facebook.com/cfafacespa?ref=hl - Facebook
       https://twitter.com/NCPlasticSurgeo - Twitter
    b. Fayetteville Plastic Surgery Specialists & Cape Fear Aesthetics MedSpa
       http://fayplasticsurgery.com/

Luxury Weight Loss Package Includes

HCG Certified Prescription
Personalized Instruction
Food Scale
Weight Scale
Hydration Container
Milestone Rewards from CFA MedSpa
Client Protocol Book
Email/Phone support by Dr. D and Staff
J's Fit Factory Personal Trainer (3 sessions) and Gym Bag
HCG Facebook page
My Diet Coach App (recommend download)

40 Day protocol ($2000 value) for $1500

Financing Options are Available

- CareCredit
  CareCredit-Apply Now
- United Medical Credit
  United Medical Credit-Apply Now
- Prosper Healthcare Lending
  Prosper Healthcare Lending-Apply Now

PHYSICIAN SUPERVISED 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 Fayetteville Plastic Surgery Cape Fear Aesthetics Medspa. 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. Edward E. Dickerson, IV, MD can work in conjunction with, but cannot replace, my regular primary care providers, such as general practitioners or other specialists in family medicine or internal medicine. I understand Dr. Edward E. Dickerson, IV, MD can only prescribe HCG and medication 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, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, 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 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 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:_____**

I understand that use of HCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Fayetteville Plastic Surgery/Cape Fear Aesthetics Med Spa providers 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. Therefore, I agree to use condoms/contraceptives and/or abstinence as birth control method for the duration of the diet. **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 Fayetteville Plastic Surgery/Cape Fear Aesthetic Med Spa providers 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 Plastic Surgery/Cape Fear Aesthetic Med Spa providers at that time.
PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Dr. Edward E. Dickerson, IV, MD 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:**_____

HCG Patient Intake Form

Patient Name: (Last)_____(First)_____(MI)_____
Patient Address: _____
City: _____ State: _____Zip: _____
Home Phone: _____Cellular:_____
Birthdates: _____Age: _____ Sex: M F Country of Birth: _____
Country of Parents' Birth: _____
Education: Elementary High School/Tech School 2-yr College 4-yr College Grad. School (Circle Highest Level)

Employment Information:
Patient Employer: _____Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip _____
Work phone No: _____Ext. _____
Social Security: _____Drivers License: _____

In Case of Emergency:
Name: _____Relationship: _____Phone:_____
Patient's Spouse: _____ Phone:_____
Family Physician: _____Phone:_____
Referred by: _____

Past History: (Please check if you have had any of the following):

□ Allergies, Type: _____ □ Birth defects or abnormalities
□ Exposed to tuberculosis □ Measles □ Scarlatina □ Influenza
□ Mumps □ Diphtheria □ Rheumatic
□ Fever German Measles (3 day) □ Polio □ Whooping Cough
□ Frequent Colds □ Chickenpox □ Tonsillitis □ Scarlet Fever
□ Pneumonia □ Diabetes:Type:
□ Cancer, Type: □ Other Diseases
□ Operations :(dates)
Current Medications (vitamins, birth control pills):
Any mood altering or depression medication:
Allergies to medicines, foods, etc

Family History:
Father: Health _____ Age _____ Deceased _____ at age _____ Cause
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause
# of siblings: _____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

□ High blood pressure	□ Allergy	□ Heart trouble	□ Anemia
□ Migraine	□ Bleeding (abnormal)	□ Dropsy	□ Epilepsy
□ Strokes	□ Cancer	□ Diabetes	□ Nervous breakdown
□ Kidney disease	□ Syphilis or (bad blood)	□ Suicide	□ Obesity
□ Arthritis	□ Rheumatic	□ Fever	

□ Other _____

Examinations:

Date of last physical examination _____ Reason:
Hospitalizations _____ Dates _____ Reason:
X-Rays: Chest _____Stomach _____Gallbladder _____ Kidney _____
Colon_____Other _____Date of last laboratory tests:_____

Electrocardiogram (heart tracing) _____ Date of last pap (cancer smear): _____

Do you now have or have had any of the following?

□ Itching	□ Eczema	□ Hives	□ Joint pains	□ Muscle aches
□ Arthritis	□ Limitation of motion	□ Backache	□ Leg pains	□ Heel Pains
□ Pain or stiffness (neck)		□ Goiter	□ Swelling, enlarged glands	
□ Asthma	□ Lung disease	□ Raise sputum	□ Emphysema Bronchitis	
□ Heart trouble		□ High blood pressure	□ Shortness of breath	□ Palpitation or fluttering □
Chest pain	□ Lips or nails turn blue		□ Tire easily	□ Swelling of ankles
□ Indigestion	□ Nausea or vomiting	□ Abdominal pain	□ Gas or bloating	□ Diarrhea
□ Hard bowel movements		No. of bowel movements - daily _____		□ Colitis
□ Jaundice	□ Hemorrhoids (piles)	□ Bleeding or black stools		□ Hernia
□ Urinary System		□ Kidney disease	□ Bladder disease	□ Kidney stones
□ Painful urination		□ Pus or blood in urine	□ Albumen or sugar in urine	
□ Dribbling of urine		□ Varicose veins	□ Nervousness or anxiety	
□ Trouble sleeping		□ Headaches	□ Bored or depressed	□ Nervous breakdown
□ Fainting		□ Convulsions	□ Numbness	□ Loss of consciousness □
Neuritis or Neuralgia		□ Paralysis		

Menstrual History:

Menstruation began at age: _____ 28 day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____
Amount of flow: _____Light _____ Med. _____Heavy _____
Date of 1st day of last: _____menstrual period:_____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____

Weight History:

When did you first become overweight? (your age then) (year) _____
How did your weight gain start? Describe any circumstances: _____
What do you think is the cause of your weight problem?_____
Your present weight: _____ your weight goal: _____height:_____
What was your highest weight? (excluding pregnancy) _____your age then _____# of years ago:_____
What was your lowest weight?_____your age then_____# of years ago:_____
Have you ever stayed the same weight for 10 years or more? Yes/ No
Have you attempted to lose weight before? _____ most lbs lost: _____how long it took:_____
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, and acupuncture) and describe your results: _____
Where and when do you do most of your overeating?_____

Please make any comments that you think might be helpful: _____

Do you currently have any medical concerns? Please List: _____

Financial Policy:

Thank you for selecting Fayetteville Plastic Surgery/Cape Fear Aesthetic Med Spa providers 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 payment for all services will be 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.

Patient's Signature: _____ Date:_____

All Statements on this patient 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: _____

Fayetteville Plastic Surgery Specialists
Cape Fear Aesthetics Med Spa

Submitting Office
Cape Fear Aesthetics
2053 Valleygate Drive
Suite 102
Fayetteville, NC 28304
Phone: (910) 323-3757 Fax: (910) 222-3068

Destination Lab
Phone: Fax:

Form # 12-0007

Patient ID:
Name:
Birth Date:

Date:
Gender:

Specimen Order Number: **12-0007 - A**

Dx: **Fatique 780.79**
Overweight 278.02

To Be Ordered: **Lipid Panel, Cortisol, DHEA, Prolactin, RPR, Estrogen, Ferritin, 17-OH Progesterone, ANA, Fe, Thryroid Function Tests (T3, T4, TSH), CBC, BMP-7**

Specimen Site:

Comments:

Any relevant previous biopsies: **No**

Instructions: Please Fax Results to 910-222-3068

Provider: Dickerson, IV, Edward E