IV Lounge by Injected Artistry
TIRZEPATIDE WEIGHT LOSS PACKAGE

Name:_____ D.O.B._____
Phone._____ Email:_____
Address:_____City:_____State: _____
Zip code:_____

In case of an emergency, please contact:
Name: _____Relationship:_____
Phone: _____

Primary Physician:_____

Are you under the care of a physician other than primary care? **Y/N**

INFO TIRZEPATIDE WEIGHT LOSS MEDICATION

Tirzepatide is is a synthetic peptide and a dual gastric inhibitory polypeptide(GIP) and a glucagon-like peptide (GLP-1) receptor agonist. It is composed of 39 amino acids and is an analog of the gastric inhibitory polypeptide.
It is used to treat type II diabetes, reduce cardiac related diseases and it also may be used as an anti-obesity medication for long-term weight management.

TIRZEPATIDE ACTS IN THE FOLLOWING WAYS

- Delays how quickly our stomachs digest food. Leading to a feeling of fullness and satisfaction with smaller meal sizes
- Lowers blood sugars, in part by reducing the production of sugar in the liver
- Stimulates insulin secretion by the pancreas when blood sugar levels are high
- Targets areas in the brain that regulate appetite and food intake
- Mimics the actions of natural GIP at the GIP receptor. At the GLP-1 receptor, though, tirzepatide shows bias towards cAMP (a messenger associated with regulation of glycogen, sugar, and lipid metabolism) generation, rather than β-arrestin recruitment

Indications for use (can be one or multiple indications):

1. BMI above healthy range
2. Type 2 diabetic
3. CAD
4. HTN
5. High LDL (or) low HDL (or) increased triglycerides
6. Body fat %27 or higher
7. At least one weight-related disease

SIDE EFFECTS OF TAKING TIRZEPATIDE INCLUDE BUT MAY NOT BE LIMITED TO:

1. Nausea
2. Muscle loss
3. Belching
4. Bloated
5. Excess air or gas in the stomach
6. Heartburn
7. Fever

8. yellow eyes or skin
9. Constipation
10. Gastric paresis

Initial that you understand side effects (_____)

PRECAUTIONS WITH THE USE OF TIRZEPATIDE

1. certain eye problems aka: diabetic retinopathy
2. disease of the pancreas aka: pancreatitis
3. Gallbladder disease
4. Kidney problems
5. Stomach or intestinal disorders aka: gastro paresis or digestive problems
6. Thyroid Disease- **this does not include high or low thyroid levels**

Initial that you understand precautions of using this medication (_____)

STRICT CONTRAINDICATIONS FOR THE USE OF TIRZEPATIDE

1. Personal or family history of Medullary thyroid cancer
2. Multiple endocrine neoplasia carcinoma
3. Type 1 diabetic
4. Pregnancy
5. Allergy to any of the ingredients (tirzepatide)

Initial that you understand strict contraindications and acknowledge you do not have any of these medical conditions (_____)

HEALTH PROFILE

The purpose of the health profile is to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on their health profile. The profile must be completed prior to beginning a weight loss program with IV Lounge by Injected Artistry.

Height:_____ Current Weight:_____

PLEASE LIST ALL YOUR MEDICATIONS & SUPPLEMENTS:

_____

DIABETES

Do you have diabetes: **Y/N** Type I Type II
Type II – Non-insulin-dependent (diabetic pills)
Type II – Insulin-dependent (diabetic pills and insulin)

CARDIOVASCULAR FUNCTION

Have you had any of the following conditions?
Arrhythmia: **Y/N** High potassium: **Y/N** Low potassium: **Y/N**
Coronary Artery Disease: **Y/N** High Blood Pressure: **Y/N**
Heart Attack: **Y/N** Blood Clots: **Y/N** Pulmonary Embolism: **Y/N**
Heart Valve Problems: **Y/N** Stroke: **Y/N** Heart attack: **Y/N**
If yes:_____

KIDNEY FUNCTION

Chronic Kidney Disease: **Y/N** Kidney Stones: **Y/N**
Kidney Transplant:**YN** Gout: **Y/N**
If yes:_____

LIVER FUNCTION

Any liver conditions: **Y/N** Gallstone issues: **Y/N**
If yes:_____

GASTROINTESTINAL FUNCTION

Constipation: **Y/N** Diverticulitis: **Y/N** Chron's : **Y/N** Reflux or GERD: **Y/N**
Irritable Bowel Syndrome: **Y/N** Ulcerative Colitis: **Y/N**
Regular Diarrhea: **Y/N** Bariatric Surgery: **Y/N** Date of surgery: _____
If yes:_____

NEUROLOGICAL & EMOTIONAL HEALTH

Alzheimer's Disease: **Y/N** Anorexia, Bulimia Or any Eating Disorder: **Y/N**
Depression: **Y/N**
If yes:_____

GENERAL HEALTH

Are you Pregnant or breastfeeding: **Y/N** Anxiety: **Y/N** Epilepsy: **Y/N**
Bipolar disorder: **Y/N** Do you have any other health issues: **Y/N**
Do you have food allergies: **Y/N** Do you ave any medication allergies: **Y/N**
If yes:_____

How much water do you drink in a day?_____
How much coffee or tea do you drink in a day?_____
How much Alcohol do you drink in a day?_____ Do you smoke? _____

I confirm that the information that I have provided to IV Lounge by Injected Artistry is true, complete, and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect , I confirm that I have disclosed all past and present physical and or mental health issues or concerns that I have experienced, including diagnoses, or surgeries that I have had. Medications and supplements that are prescribed or that you take. (_____)

I understand that if I have not disclosed medical information to IV Lounge by Injected Artistry and I chose to follow the Weight Loss Protocol provided by IV Lounge by Injected Artistry, such decisions will be completely voluntary. Also, I release Jamie Slovenski RN, Ken Starr MD and all team members of IV Lounge by Injected Artistry and Ken Starr MD wellness from any & all damages, liability, claims and causes of action of any nature whatsoever that may result from such voluntary and informed decision of this weight loss program provided by IV Lounge by Injected Artistry. (_____)

By signing this contract I am Agreeing to release all medical malpractice. I Choose to have any issues decided by neutral arbitration and I am giving up my right to jury or court trial. The weight loss program has been thoroughly explained to me and I have had opportunities to ask any questions or express any concerns and these questions or concerns have been answered to my satisfaction. (_____)

I am committed to a **once a week on the same day of each week for the entire program**. If you miss a day there are **no refunds**. (_____) Please let me know if you will be out of town the week before so I can arrange other options.

COST OF TREATMENT:

Tirzepatide Dosing Chart			Cost (month/dose)
Dose	Units	MLs	
$250 MONTH			
1.25mg (maintenance dose)	12.5 units		$250/$62.50
$500 MONTH			
2.5mg	25 units		$500/$125
3mg	30 units		$500/$125
4mg	40 units		$500/$125
5mg	50 units		$500/$125
$600 MONTH			
6mg	60 units		$600/$150
7mg	70 units		$600/$150
8mg	80 units		$600/$150
9mg	90 units		$600/$150
10mg	100 units	1 ml	$600/$150
$700 MONTH			
11mg	50 units		$700/$175
12mg	50 units		$700/$175
13mg	50 units		$700/$175
14mg	50 units		$700/$175
15mg	50 units		$700/$175

YOUR SIGNATURE STATING THAT YOU UNDERSTAND ALL INFORMATION.

I have read and fully understood these risks completely give my consent for treatment of Tirzepatide.

Print First & Last Name: _____

Signature: _____ Date:_____

Our goal is to encourage you through this journey of self love and self worth!