Medical Weight Management Program Treatment Consent Form

Authorization for Examination and Treatment

1. Having been explained the risks and benefits of the Medical Weight Management Program a medically monitored program for rapid, safe* weight loss and complete education to help manage weight. I knowingly and voluntarily desire to participate in the Program.
2. I am aware that I must meet medical and psychological screening criteria established by the Medical team of weight management professionals before entering the Program.
3. I hereby authorize and consent to have Program physicians perform complete physical and diagnostic procedures including blood test, electrocardiogram (EKG), and possibly a stress test and/or chest radiography for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.
4. As part of the Medical Program, continuous medical monitoring is mandatory. Consequently, upon acceptance to the Program, I willingly agree to have this monitoring performed (blood tests, periodic EKG, and other tests as indicated).
5. I am aware during the weight loss period possible side effects may occur from ketosis. Ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). These side effects include dizziness and fruity breath. Less common, but possible side effects are fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea and constipation.
6. I have been informed that foot-drop is a rare transitory side effect of weight loss.
7. I have been informed that any weight loss regimen increases the chance of gallstone formation.
8. If medical complications unrelated to weight loss arise during the Program, I am fully aware I will be referred back to my private physician for treatment and evaluation.
9. I recognize that if I should become pregnant my participation in the (if applicable) Program must be terminated.
10. I understand that I will pay for my products and program services on a weekly basis. I understand that it is my responsibility to pay for these services.
11. The physician/nurse practitioner team of weight management professionals has answered my questions regarding this Program and possible side effects.

Patient Signature: ______________________________ Date: ____________________

Staff Signature: ______________________________ Date: ____________________

**Physician monitoring is required to help minimize the potential for health risks.*