Weight Loss Program Consent Form

I _____ authorize ***Family Medicine Associates of Lincoln County, PLLC*** and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced high protein, low carbohydrate, low calorie diet, a regular exercise program, and instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include the use of weekly HCG (Human Chorionic Gonatrophin) injections. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature. I understand that it is a ***FEDERAL FELONY*** to use diet pills for any non-medical purpose. Therefore, anyone that is found using appetite suppressants for energy or other purposes will be permanently discharged from the weight loss program.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. I understand that a low dose of HCG may be part of my treatment plan; however I understand that there are possible risks of birth defects with high doses of HCG if taken while pregnant. I am currently NOT pregnant nor am I planning to become pregnant while taking injections. I will take measures to prevent pregnancy while I am undergoing weight loss treatment. In the event that I do become pregnant, I will stop any treatments related to the weight loss program. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form. I realize I should not sign this form if all items have not been explained to me and my questions have not been answered to my complete satisfaction. If you have any questions what so ever regarding the risks or hazards of the possible treatments, ask your doctor now before signing this consent form.

Patient: _____

Date: _____