**WEIGHT LOSS PROGRAM INFORMED CONSENT**

I request strict dietary restrictions for the purpose of weight loss. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own provider or have them ordered through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that for weight loss visits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can only prescribe weight loss related medication necessary for this treatment and all other health matters should be handled on a separate visit or through my regular provider.

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, 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 treatment.

Initials:\_\_\_\_\_\_\_\_\_\_

There are side effects that can include but are not limited to:

|  |  |
| --- | --- |
| * Ovarian Hyper-Stimulation Syndrome (OHSS)
* Arterial Thromboembolism
* Blood Clots
* Risk of multiple pregnancies
* Hair Loss
* Over stimulation of the ovaries causing production of many eggs in women
* Tiredness and/or weakness
* Changes in mood
* Skin irritation or rash
* Chest pains
* Low or reduced sex drive
* Inability to have or keep an erection
* Blurred vision or temporary blindness
* Convulsions
* Trouble speaking
* Difficult or painful urination
* Bleeding/Bruising
 | * Acne
* Excessive fluid retention in the body tissues, swelling (edema), numbness/tingling, trembling
* Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
* Prostate hypertrophy
* Abnormal enlargement of breasts in men
* Difficulty breathing
* Fast, irregular, pounding or racing heartbeat or pulse
* Headaches
* Dizziness
* Mental changes
* Hives
* Fainting
* Death
 |

I understand weight loss treatments may involve these risks and other unknown risks. Initials:\_\_\_\_\_\_\_\_\_\_

I understand that weight loss treatments are absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform my provider if I am pregnant, if I am trying to become pregnant or if I become pregnant during these treatments. 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 because of this. Initials:\_\_\_\_\_\_\_\_\_\_\_

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, if an illness does occur, I understand that I need to contact my provider immediately. If I experience an emergency, I understand that I need to go to an emergency facility immediately. Initials:\_\_\_\_\_\_\_\_\_\_

I understand that if there are any changes in my medical history or are any changes in my medications or any other changes relevant to this program, I will advise my provider. 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 program. In the event a dispute arises over the outcome, I consent solely to arbitration as a legal means of settlement.

Patient’s Name Printed:

Patient’s Name Signed:

Provider’s Name Printed:

Provider’s Name Signed: