Weight Management Consent Form

I, _____ ___ hereby authorize Glow Health Medical Clinic to provide medical care to me, including but not limited to the treatment of my weight problem and any coexisting medical conditions. This may involve but not be limited to history taking, in-office testing and physical examination, additional laboratory testing. (Please initial each paragraph. If you have any questions please feel free to ask them of your physician.)

____ I understand that my weight management treatment may consist of specific diet plans, for example a balanced deficit diet, very low calorie diet, a protein supplemented diet; recommendations for behavior modification techniques, including prescribed regular exercise regimens; and possibly the use of over-the-counter and prescription medications, e.g. appetite suppressants. I understand that I may be prescribed medications for medical conditions other than those relating to my weight management according to general medical practice standards.

____ I understand that if medications are prescribed, especially medications for weight control, their duration of use and prescribed dosage and frequency may exceed or vary with those indicated in the package insert or those set forth by the FDA. It has been explained to me that these medications have been used safely and successfully in private and academic medical practice with appropriate monitoring for periods and at dosing and frequency regimens exceeding or at variance with those recommended in the product literature.

____ I understand that any medical intervention has associated potential risks and benefits. Risks of this program may include but are not limited to tiredness, weakness, sleep disturbances, headaches, dry mouth, gastrointestinal disturbances, nervousness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. In rare instances these and other possible risks could be serious or even fatal. The benefits of successful weight management may include but not be limited to improved overall health, lower risk of developing serious diseases with at times fatal complications, such as diabetes, breathing problems, joint

degeneration, high blood pressure, heart disease, circulation problems, heart attack, stroke, et al.

____ I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs not supervised by a physician. I also understand that remaining overweight or obese puts me at greater risk for ill health. Some of the complications that may develop as a consequence of prolonged abnormal body weight are arthritis of the joints, especially weight-bearing joints such as hips, knees, feet and back, high cholesterol and triglycerides, high blood pressure, diabetes, vascular disease complicated by stroke, heart attack and abnormal heart rhythms, gallstones, 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 the success of weight management treatment depends on my active participation. Glow Health Medical Clinic cannot guarantee or assure treatment success or any definite outcome. I understand that obesity is considered a chronic condition that may require permanent changes in my eating habits and behavior to attempt success at treatment.

____ I have read and fully understand this consent form and I realize I should not sign this form if all items have not been satisfactorily explained to me. With my signature I acknowledge that my questions have been answered fully, and that I have been requested to read this form and have been given ample time to understand all its contents. If at this time you have any questions regarding the risks or dangers of the proposed treatment or would like further explanations concerning the proposed treatment or any alternative options, ask your doctor now before signing this consent form.

Glow Health
MEDICAL CLINIC

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_____

(Patient Name – Please Print)

_____ _____

(Patient Signature or Signature of Authorized Patient Representative) (Date)

_____ _____

(Witness Name and Signature) Date