MEDICAL WEIGHT MANAGEMENT PROGRAM

MyCatholicDoctor

CONSENT FORM

I, _____ authorize MyCatholicDoctor PLLC, to help me in my weight reduction efforts. I understand that my program may consist of a balanced, reduced-calorie diet, a regular exercise program, instruction on behavior modification techniques, and coaching. It may also involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

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 being overweight and with obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, increase or slowing of the heartbeat and heart rhythm irregularities, and risk of weight re-gain. These and other possible risks could, on occasion, be serious or even fatal.

Risks associated with remaining overweight or obese may include but are not limited to high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis, 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 over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in food and activity habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____

Patient's Name (printed)

_____ _____

Patient Signature
(or signature of person with authority to consent for patient)

Date