PATIENT WEIGHT LOSS CONSENT –

I am authorizing WFHN Bariatric & Weight Management – Gatewood to assist me in my current health and wellness, and weight loss efforts. I understand this attempt is a partnership, in that there must be open communication and that all follow up appointments must be kept or rescheduled in an effort to remain on track and successful. This program may consist of, but not be limited to meal planning (calorie diets based on insulin sensitivity and weight loss goals, nutritional coaching, etc.), regular exercise encouragement, instruction in behavior modification techniques, and/or supplemental vitamins/minerals.

This program may or may not involve the use of appetite suppressants. I must understand that if appetite suppressants are utilized, they may be used for durations exceeding those recommended in the medication package insert. Medication therapy is only prescribed at the discretion of the Physician Assistant. I am consenting that it is her choice to use these medication longer than the package insert and if I do choose to do so, it is at my will.

I understand that many medical treatments involve risks as well as the proposed benefits. I also understand that there is certain health risks associated with remaining overweight. Risks of this program and the use of appetite suppressants, if in which this program applies to me, may include but are not limited to nervousness, restlessness, dry mouth, fatigue, elevated blood pressure, heart abnormalities, headaches and gastrointestinal irregularities. These and other possible risks could have long term effects and may be fatal.

I understand that risks associated with remaining overweight—but not limited to—increased risk for high blood pressure, diabetes, heart disease, arthritis of the joints, reflux, high cholesterol, sleep apnea, depression, and possible sudden death. These risks may be modest if an individual is not significantly overweight but will increase with additional weight gain.

I understand that the success of the program will depend on my efforts, my follow up, and my body chemistry, and that there are no direct guarantees or assurances made for me directly to me that the program will be successful for me. 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 understand there are many significant health risks associated with obesity including, but not limited to: hypertension (high blood pressure), high cholesterol, blood vessel disease, thyroid, and other endocrine (hormonal) disorders. These diseases can result in heart attack, stroke, and can affect eyesight, kidney, lung, and brain functions along with many other serious results. These conditions require a level of ongoing care and management (called “continuity of care”) far beyond that of any wellness center. Therefore, WFHN Bariatric & Weight Management – Gatewood is not a substitute for a patient having a “primary care” doctor.

We ask that patients have a “primary care” doctor to whom they can be referred for evaluation and management of blood pressure, diabetes, hypertension, and other medical problems. Please be advised that WHEN INDICATED, you may be prescribed a controlled substance in the form of an appetite suppressant that may raise your blood pressure. **We accept patients with high blood pressure if they are on blood pressure medication and their blood pressure is under control (less than 140/90).**

WFHN Bariatric & Weight Management – Gatewood also offers meal replacements and dietary supplements to assist you you're your weight loss. WFHN Bariatric & Weight Management – Gatewood does not offer refunds on any services or products, including time and pharmaceuticals, rendered.

At the time of service you agree to commit to being financially responsible for payment of your office visits and additional products at the time of service unless some other payment arrangement is agreed upon with the management of WFHN Bariatric & Weight Management – Gatewood. I understand that refunds are never given under any circumstances.

I have read and understand the above. I am authorizing to give my consent to Brittany Shaw, Physician Assistant and her co-workers to help me in my weight reduction efforts. I understand that it is my responsibility to follow the instructions carefully and to timely report to WFHN Bariatric & Weight Management – Gatewood any significant medical problems that I think may be related to my weight loss program. If I develop side effects from the diet or medications, I will discontinue the weight loss program and seek medical treatment at the nearest emergency room or contact my primary care doctor. Again, you understand that WFHN Bariatric & Weight Management – Gatewood does not offer refunds on any services or products, including time and pharmaceuticals, rendered.

I understand that I must provide Brittany Shaw, Physician Assistant and her co-workers my medical history including all medications that I currently take. I also understand that I must update this information if it changes.

I acknowledge that I understand the risks of the proposed treatment, and the medical staff of WFHN Bariatric & Weight Management – Gatewood has answered all of my concerns regarding my care.

_____ _____

Patient Signature Date

_____

Print Name

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. I understand and acknowledge that treatment by WFHN Bariatric & Weight Management – Gatewood, Brittany Shaw, PAC and their designated co-workers is limited solely to assistance with weight reduction efforts. This treatment does not provide a substitute or replacement for any regular physician. WFHN Bariatric & Weight Management – Gatewood and Brittany Shaw, PAC does not treat acute or chronic medical problems, and I agree to see my regular physician for these problems.

II.

1. I authorize Brittany Shaw, PAC and her co-workers to assist me in my weight reduction efforts. I understand my treatment may involve but not be limited to, the use of appetite suppressants for 12 weeks or longer and when indicated in higher doses than the dose indicated in the appetite suppressant labeling. I understand that my program may consist of a balanced calorie-restricted diet, a regular exercise program, and instructions in behavior modification techniques, and may involve the use of appetite suppressant medications.
2. I have read and understand my medical provider's statements that follow:
   "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."
   "As a medical provider, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a medical provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."
   "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."
   "As a medical provider, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."
3. I understand it is my responsibility to follow the instructions carefully and to report to the medical provider treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.
5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

III.

1. RISKS OF PROPOSED TREATMENT:

   I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

2. NO GUARANTEE:

   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 I will have to continue watching my weight all my life if I am to be successful.

3. PATIENT'S CONSENT:

   I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction, I have been urged to take all the time I need in reading and understanding this form and in talking with my medical provider regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I also understand that participation in this program is strictly voluntary and is my choice to participate or not. I understand that I may discontinue this treatment at any time at my discretion.

4. WARNING:

   IF YOU HAVE ANY QUESTION AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR MEDICAL PROVIDER NOW BEFORE SIGNING THE CONSENT SIGNATURE FORM.

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. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.
(If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.)

☐ **I agree to the PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS**

_____ _____

Patient Signature Date

_____

Print Name