INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Health Plus to assist me in my weight reduction efforts.

I understand that I will be asked to make lifestyle changes, particularly related to diet and activity.

I understand that much of the success of the program will depend on my efforts.

I understand that there are no guarantees that the program will be successful.

I understand that I will need to continue to make lifestyle changes, particularly related to diet and exercise, after I am no longer a patient at Health Plus, or I am likely to regain weight.

I agree to inform my Health Plus practitioner of all health problems and medical conditions that I currently have and of any new health problems or medical conditions that develop during my treatment at Health Plus. I agree that should I develop new health problems while I am a patient at Health Plus I will inform my Health Plus practitioner as soon as possible.

I agree to inform my Health Plus practitioner of all prescription medications, over the counter medications and nutritional supplements that I am taking. If I start taking new medications or supplements while I am a Health Plus patient I will inform my Health Plus practitioner as soon as possible.

I understand it is my responsibility to carefully follow the instructions given to me by my Health Plus practitioner.

I accept full responsibility for any problems or complications that occur as a result of my withholding medical information or not following directions.

I understand that it is unhealthy and possibly harmful to the fetus to attempt weight loss while pregnant. I am not pregnant now and am not seeking to become pregnant. Should I become pregnant while I am Health Plus patient I agree to inform my Health Plus practitioner as soon as possible.

When appropriate and when indicated your Health Plus practitioner may temporarily treat chronic medical conditions other than obesity. However, I understand that Health Plus does not provide primary health care. It is strongly recommended that you have a primary health care provider. Your Health Plus practitioner, with your written consent, is happy to talk to your primary care provider.

I understand that Health Plus does not provide emergency medical treatment, and that your Health Plus practitioner may not be available after hours. If I have a medical emergency I understand I should call 911 or go to a hospital emergency department.

I have read and fully understand this consent form and I realize I should not sign this form if I do not understand it completely. I affirm that I have had the opportunity to ask questions about the content of this form, and all my questions have been answered to my full satisfaction. I affirm that I have had as much time as I need to read this form in its entirety.

Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_