WeCare Family Medicine, LLC

Medicalyl Supervised Weight Loss

Consent Form

I, _____ authorize **WeCare Family Medicine, LLC** and whomever they designate as their assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balance nutritional diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplement diet. I further understand that if appetite suppressant are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me these medications have been used safely and successfully in private medical practices 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 risks associated with remaining overweight or obesity. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances , weakness, tiredness, psychological problems, high problems, rapid heartbeat, and heart irregularities. These and other possible risks could on occasion be serious or even fatal. Risks associated with remaining are tendencies to high blood pressure, diabetes, heart attack and heart disease , I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be chronic, life-long condition that may require changes in my eating habits and permanent changes in my behavior to be treated successfully.

I have read and fully understand this consent form and 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 given all the time needed 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 THE POSSIBLE TREATMENTS , *ASK YOUR DOCTOR NOW BEFORE SIGNING THE CONSENT FORM.*

Date:_____ Patient Signature : _____