



Client Informed Consent Participation in a Weight Management Program

Client Name: _____

Date of Birth _____

I. Procedure and Alternatives:

1. I, _____ (Client or Client's guardian) authorize _____ and his (or her) associates or assistants to assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual Client. These may utilize a very low calorie diet, or a protein supplemented diet.
2. I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that I think maybe related to my weight control problem as soon as reasonably possible to the doctor treating.
3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive treatment will be dependent on my progress in weight reduction and weight maintenance.
4. I understand the medical exam by the Physician is not a complete exam. I have been advised that I still need to visit my Primary Care Physician for regular physical exams.

II. Risks of Proposed Treatment:

1. Vitamins and minerals - nausea, rash, constipation, diarrhea.
2. Potassium - heartburn, nausea.
3. Thyroid - vomiting, increased heart rate, chest pain, nervousness, tremors, menstrual irregularity, and/or nausea.

I understand that if I develop side effects from the diet or medication, I will discontinue the diet and/or the medication(s) and notify the medical staff as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (Take your medications with you)

III. Risks associated with Being Overweight or Obese:

1. I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies for high blood pressure, diabetes, heart attack, heart disease and arthritis of the hips, joints, knees, and feet. I understand that these risks may be modest if I am not very much overweight but the risks increases significantly the more overweight I am.
2. I understand that thirty (30) to forty (40) percent of overweight or obese Clients may have or develop gallstones. A large percentage of this group will develop symptomatic gallbladder disease during their lifetime. I understand that certain types of weight reduction programs may increase the chance of developing symptomatic gallbladder disease.

IV. No Guarantees:

- 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 of my life if I am to be successful.
- I understand that I will not receive any refund for any treatment if I am not successful. I understand that there is an initial fee, a fee every four weeks and a fee for products.
- I understand that I will not be able to return or receive funds for any product I purchase; it is my responsibility to inspect products before I leave the counter.
- I understand that if I cannot make a scheduled appointment, it is my responsibility to cancel within 24 hours. I understand that failing to do so will result in my being charged a "no show" charge for that appointment.

Initials: _____

V. Client's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if any 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 doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I acknowledge that I have been provided a copy of Notice of Privacy Practices.

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

Date: _____

Time: _____

Signature: _____

Witness: _____

Client Signature or person with authority to consent for Client

VI. Physician Declaration:

I have explained the contents of this document to the Client and have answered all the Client's related questions to the best of my knowledge. I feel the Client has been adequately informed concerning the benefits and the risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the Client has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician Signature: _____

Date: _____

OPTIONAL TALENT RELEASE:

Talent hereby expressly grants to the weight loss center and its employees, agents, assigns or re-assigns, hereinafter known as the "Company", the unlimited and perpetual rights to use, copy, and distribute any photographs, images or likeness of Talent in any fashion for the promotion of the Company including commercial and non-commercial exposition which may include but is not limited to: printed media, television, video, or in any other medium.

I also hereby consent and agree that as part of this Agreement, I hereby grant the Company the unlimited right to photograph me otherwise record my image and likeness using any technology the company deems suitable and use said images or data in an unlimited fashion.

The Company shall not have any obligation to use Talent's image or likeness. I agree that I will not assert or maintain against you, your successors, assigns and licensees, any claim, action, suit or demand of any kind or nature whatsoever, including but not limited to, invasion of privacy, rights of publicity or other civil rights, or for any other reason in connection with your use of my physical likeness by the Company.

I certify that I am over 18 years of age and I am legally and mentally qualified to execute this agreement. I have read and fully understand the meaning and effect of this release and I agree to be legally bound by this agreement in its entirety.

Date: _____

Time: _____

Signature: _____

Witness: _____

Client Signature or person with authority to consent for Client