DERBY  DERM

Patient Consent for Medical Weight Loss

I,_____ hereby authorize Tim Weide, PA and his staff to provide medical care to me, including but not limited to the treatment of my weight problem. This may involve but not be limited to history taking, in-office testing and physical examination, additional laboratory testing.

(Please initial each paragraph.)

____ I understand that any medical intervention has associated potential risks and benefits. Risks of this program may include but are not limited to sleep disturbances, headaches, gastrointestinal disturbances, nervousness, rapid heartbeat, and heart irregularities. The benefits of successful weight management may include but not be limited to improved overall health, lower risk of developing serious diseases with at times fatal complications, such as diabetes, breathing problems, joint degeneration, high blood pressure, heart disease, circulation problems, heart attack, stroke, et al.

____ I understand that I have alternative treatment options, including but not limited to no treatment and weight management programs not medically supervised. I also understand that remaining overweight or obese puts me at greater risk for ill health. Some of the complications that may develop as a consequence of prolonged abnormal body weight are arthritis of the joints, especially weight-bearing joints such as hips, knees, feet and back, high cholesterol and triglycerides, high blood pressure, diabetes, vascular disease complicated by stroke, heart attack and abnormal heart rhythms, gallstones, 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.

____ I understand that the success of weight management treatment depends on my active participation. Derby Derm cannot guarantee or assure treatment success or any definite outcome. I understand that obesity is considered a chronic condition that may require permanent changes in my eating habits and behavior.

____ I understand that all lab work performed at Derby Derm, including but not limited to EKGs and blood work, is done for weight loss screening purposes only. It is in no way intended to replace the need to see my primary care physician or specialist. It also does not replace my need to do regular lab work, EKGs or other tests.

____ I have read and fully understand this consent form and I realize I should not sign this form if all items have not been satisfactorily explained to me. With my signature I acknowledge that my questions have been answered fully, and that I have been requested to read this form and have been given ample time to understand all its contents.

_____

(Patient Name – Please Print)

_____ _____

(Patient Signature or Signature of Authorized Patient Representative) (Date and Time)

_____ _____

(Witness Name and Signature) (Date and Time)