

Consent for Medical Weight Loss Treatment

I, _____, (patient or guardian) do hereby authorize the physicians of the Aspen Clinic, Inc. to assist me in weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that in order to continue to receive appetite suppressants, I must show continued weight loss.

Regarding the use of appetite suppressants, I understand that there are potential risks involved. Reported side effects include nervousness, constipation, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat and heart irregularities. I understand that these and other risks could, on occasion, be serious and possibly permanently disabling. _____ *initial* I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Aspen Clinic staff, as well as my primary care physician, immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. _____ *initial* I agree not to take any other weight loss medications, other than those prescribed by the physicians of the Aspen Clinic and further agree to inform the Aspen Clinic staff of ANY changes in my medication or medical history. _____ *initial*

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 appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis of the joints, hips, knees and feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

_____ *initial*

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling, and at times in larger doses than those suggested in the labeling. The physicians of the Aspen Clinic are not required to use the medications as the labeling suggests, but do use it as a source of information along with their own experience, the experiences or their colleagues, recent studies and recommendations of investigators. Based on these, they may choose, when indicated, to use the appetite suppressants for longer periods of times and in increased doses. As a patient of the Aspen Clinic, I understand that I may be prescribed medications as stated above.

_____ *initial*

There is no guarantee that this program will work for me. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by insurance and Aspen Clinic does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out.

By signing below I certify that I have read and fully understand this consent form and understand the risks associated with my treatment for weight loss.

Patient: _____ Date: _____

Witness _____