PRIMARY CARE OF SOUTHERN TEXAS
Cypress Medical Plaza
27160 US-290 Suit 207
Cypress, TX 77429

Weight Loss Program Consent Form

I, _____authorize PRIMARY CARE OF SOUTHERN TEXAS and whoever is designated as Physician or Provider by the clinic, to help me in my weight reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of weight management medications. Other treatment options may include a very- low-calorie diet, or a protein-supplemented diet. I further understand that if medications are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that 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 health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tired- ness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, 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 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 a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I 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 been given all the time I need to read and understand this form.

_____
Patient's Name (printed)

_____ _____
Signature (or person with authority to consent for patient) Date

Witness: _____

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.