ReforMedicine SC
Direct Pay Family Practice

Weight Loss Program Consent Form

I, ___________________________________, authorize my ReforMedicine, SC physician(s), or advanced practice clinician (s) and/or whomever may be designated as the medical assistant(s), 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 in behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction 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 medication 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 associated with remaining overweight are tendencies to have high and increasing higher 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 made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

I understand that failing to show up for an appointment I have scheduled, without calling or contacting ReforMedicine, SC ahead of time, represents a disruption to operation of the clinic. If I should fail to call or contact ReforMedicine, SC and cancel prior to the start of the appointment, I understand NO further appointments will be scheduled for me unless I pre-pay the appointment no later than one (1) business day prior to the visit. If this should occur a second time without calling ahead to cancel or reschedule (a "no show"), ***I understand that I will pay the full office visit charge for that missed appointment ($95)****, in addition to pre-payment for the rescheduled visit.*

Rev. 1/18/16

I have read and fully understand this consent form and "no show" policy. I have had all of my questions answered to my complete satisfaction. I have been given all the time that I need to carefully read and understand this form.

Signed,

Patient Full Name: ____

(Or person and relationship with authority to consent for the patient)

Date: ____