ROCHESTER MEDICAL WEIGHT LOSS, P.C.

MEDICAL WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize Dr. Gule-Rana Masood and the staff of Rochester Medical Weight Loss, P.C., to provide me with a program of medical weight loss treatment to assist me in my weight reduction efforts. I understand that my treatment program may include of one, more or all of the following: diagnostic procedures that include metabolic evaluation and blood tests; and treatments plans which include a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques and the use of prescription appetite suppressant medications. Other treatment options may include a very low calorie diet and/or a protein and vitamin supplemented diet.

I further understand that my weight loss program may include FDA approved appetite suppressant medications. These medications may be used at doses higher, and for periods of time longer than the dosages and duration recommended in the labeling and package inserts for such medications. 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 at dosages and for time periods exceeding on the product labeling.

I acknowledge that the medical weight loss program provided to me may include use of natural formulations, nutritional supplements, vitamin products and other items which have not been evaluated by the FDA. In keeping with government regulations, I acknowledge that Rochester Medical Weight Loss, P.C. makes no therapeutic or medical claims with respect to those products.

I understand it is my responsibility to follow the instructions given to me with respect to the use of medication and other products carefully and to promptly report to Dr. Masood any significant medical problems that I think may be related to my weight control program as soon as possible.

It has been explained to me that medical weight loss treatment has risks as well as proposed benefits. The risks explained to me include, but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, fatigue, anxiety, depression, high blood pressure, rapid heartbeat and heart irregularities. These are other possible risks could, on occasion, be serious or even fatal. Please consult the separate information packet given to you for other potential risks of medical weight loss treatments.

I also understand that there are certain health risks associated with remaining overweight or obese. These include, but are not limited to, tendencies to have high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. The risks of being overweight may be modest if I am not significantly overweight, but will increase with additional weight gain.

Alternatives to my pursuing a course of medical weight loss treatment have also been explained to me. These included non-prescription products, personal behavior modification and diet control, exercise and in some cases surgery. Despite these and other alternatives, my signature below will signify my decision to proceed with a program of medical weight loss with Rochester Medical Weight Loss, P.C.

I understand that much of the success of the program and my treatment will depend on my personal efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I acknowledge that I have a right to discontinue treatment at Rochester Medical Weight Loss, P.C. at any time. In the event that I choose to discontinue treatment, I will give written notice of my decision to Rochester Medical Weight Loss, P.C. I will also immediately consult with my primary care physician concerning my medical care after leaving treatment.

Women only: I understand that weight loss medication and should not be taken during pregnancy, due to the change of damage to the fetus. I also understand that a low calorie diet is not appropriate during pregnancy and my damage the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that I should be taken to avoid pregnancy while I am on medication or a restricted diet. If I become pregnant, I will advise both Rochester Medical Weight Loss, P.C. and my OB/GYN immediately.

[If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment, alternatives or this Consent Form, please ask Dr. Masood now before signing this Consent Form.]

I have read and fully understand this Consent Form. I realized that I should not sign this Consent Form if all items have not been explained to me or if I have any questions or concerns that have not been answered. By signing below I certify that my questions have been answered to my complete satisfactions and that I have been given all the time I need to read and understand this form.

Date: _____ Time: _____

Patient Signature: _____

Office Personnel/ Witness: _____

If patient is a minor or otherwise incapacitated:

_____

Signature of Parent or Person with authority to consent for patient

Print Name: _____

Relation to Patient: _____

I have received a copy of this signed consent form.

_____

Patient or Guardian