



## *Integrative Weight Loss & Wellness*

### **Patient Agreement and Consent to Treatment**

I, \_\_\_\_\_, authorize Integrative Weight Loss & Wellness and associates to assist me in my weight reduction efforts. Any successful weight-loss program requires that I be fully committed to making the appropriate lifestyle changes. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, supplements, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these FDA-approved medications have been used safely and successfully for decades for periods exceeding those recommended in the product literature.

I realize that there are serious health risks that are associated with being overweight and I am willing to change my practices to improve my health and well-being. Risks associate with remaining overweight are tendencies to high blood pressure, diabetes, heart attack, heart disease, arthritis, sleep apnea, certain types of cancer, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but they may increase significantly the more overweight I am.

Integrative Weight Loss & Wellness's programs offer protocols that require continued medical supervision during the Acute Weight Loss Phase. As the patient, I am responsible for reading the materials, following the program as directed, and keeping my weekly appointments. I understand that my continuing to receive medication will be dependent on my progress in weight reduction and weight maintenance. I will take my medication as directed and never share my medication with friends or family.

I understand that Integrative Weight Loss & Wellness cannot guarantee that the program will work for me. They will offer all of their resources to help me achieve the best results possible. I understand that services are not reimbursed by insurance and Integrative Weight Loss & Wellness does not provide or fill out claims for insurance purposes. I may contact my benefits administrator to see if the services are covered under a Health Spending or Flexible Spending account. I may also consult the IRS to see if these services qualify as medical expenses.

The medication has a long history of safe use, but like all medications, patients can experience side effects with them. Risks of this program may include nervousness, headaches, dry mouth, insomnia, gastrointestinal disturbances, weakness, fatigue, medication allergic reaction, high blood pressure, rapid heartbeat, and irregular heart rhythm. These and other risks could, on occasion, be serious. If I experience any side effects from the medication or diet, I will discontinue the diet and/or medication and notify Integrative WLW staff. As always, if I am experiencing a medical emergency, I will seek emergency treatment immediately.

I will not combine these medications with any other appetite suppressants, herbal remedies, or non-prescription stimulants. I have provided a thorough medical history and have reported all medications



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that I am taking. I will notify Integrative Weight Loss & Wellness if my medication regimen should change.

I will notify Integrative Weight Loss & Wellness of any upcoming events (i.e. surgeries, vacations, cessation of program, etc.) so that they may plan my treatment accordingly. I will immediately notify them if I should find out that I am pregnant or if I plan on becoming pregnant.

I understand that Integrative Weight Loss & Wellness has a Notice of Privacy Practices and I acknowledge that I have received a copy, if requested. My signature below indicates my consent to treatment. I have read and fully understand this agreement and consent form. I realize that I should not sign this form if I have any questions or concerns that have not been fully addressed. I will sign this form after my questions have been answered to my complete satisfaction.

I understand that any Integrative Weight Loss & Wellness materials are only for my own use and that I will not duplicate, sell, lend, or otherwise transfer them to any other person.

### *\*Payment structure\**

By consenting to treatment, I agree to pay in full for all visits and charges via credit card/check. If patient is waiting for approval for payment via Health Savings Plan, FLEX spending plan, traditional insurance plan, or any other assisted health care payment plan, patient is responsible for current charges via credit card/check until alternate payment is approved.

For the initial appointment, I will be charged for the appointment, supplements, and the prorated portion of the weekly visits remaining until the end of the month. I understand that Integrative Weight Loss & Wellness will bill me on a recurring basis at the beginning of every calendar month on a current credit card and will keep the information current. I must inform Integrative Weight Loss & Wellness of any cessation of the program prior to the 25<sup>th</sup> of the month or the following month will be billed without refund. All monthly program fees include weekly visits, prescription medication, and MIC injection. I understand that missed weekly visits for any reason (including vacation, scheduling issues, etc.) are not credited or carried over to the following month for any reason.

I have read and understand the above agreement. I'm ready to get started!

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The success and safety of your weight loss requires that you follow our instructions and program design. As always, please ask or call us if you ever have any questions.

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Patient's Signature

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Date

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Print Name



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### **Physician/Nurse Practitioner Declaration:**

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the program.

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Provider Signature