Patient Informed Consent for Weight Loss

Procedure and Alternatives:

I, _____ (patient or patient's guardian) authorize the doctor to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants, the use of HCG and other medications as needed for more than 12 weeks.

I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as reasonably possible.

I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

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 I will have to continue watching my weight all of my life if I am to be successful.

I understand that use of HCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform the Doctor if I am CURRENTLY pregnant, if I am TRYING to become pregnant or if I BECOME pregnant during the course of these treatments.

I understand that HCG is used in infertility treatments, and therefore I have an increased chance of pregnancy while on HCG. Multiple birth control methods should be used while on HCG. However, HCG is contraindicated for women using IUD for birth control.

Patient Consent

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, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

Date: _____ Patient Signature (or guardian) _____

Time: _____ Witness: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby grant Malissa Spacek and James R. Campbell, D.O. and designated members of their staff, permission to contact me and leave messages pertaining to my medical care (including calling to remind me of appointments at their office to inform me of referral appointments, test results, prescription information etc.) with those listed below.

NOTICE OF RECEIPT OF PRIVACY PRACTICES

I have been presented with a copy of the privacy practices (required by HIPAA) for the office of BA Med Spa & Weight Loss Center.

I have been given the opportunity to read the notice and receive clarification of any questions I may have, and to obtain a copy.

Signed: _____ Date: _____