





## Personal Information

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address:

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Maiden name: \_\_\_\_\_

Spouse name: \_\_\_\_\_ Tel: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Tel: \_\_\_\_\_ Relationship: \_\_\_\_\_

## How did you hear about us?

Relative/Friend: \_\_\_\_\_  
Please provide name and if possible DOB

Radio: \_\_\_\_\_  
Please provide station (93.9, 102.3, 104.1, 107.9)

Internet: \_\_\_\_\_  
Please provide site (i.e. weight loss forum, Yelp, Facebook, website)

Other: \_\_\_\_\_  
Please provide details (Former Patient, etc.)

## Information and Assignment of Benefits

I authorize the release of medical information to my primary care physician, referring physician, or consults if needed. I understand that payment is required for all services at the time they are rendered. Please note that Right Weight Clinics will not present a bill to any insurance company for its services. Right Weight will provide you a receipt for your visit and will not complete any specific forms that the insurance companies provide.

I certify that the information I have reported above is correct. I had the opportunity to ask questions regarding this issue. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## WEIGHT LOSS CONSENT FORM

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE WEIGHT LOSS PROGRAM DESCRIBED IN THIS INFORMED CONSENT.** I understand that my program may consist of a balanced deficit diet, injections, a regular exercise program, instruction in behavior modification techniques, and 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. I understand that any medical treatment using medications there are certain risks associated that were mentioned in this consent but most importantly there are many benefits associated with weight loss.

I understand that weight loss improves obesity related conditions such as: High blood pressure, High cholesterol, Sleep apnea, Arthritis, Diabetes, Increased energy level, reduces aches and pains, improves mobility, improves breathing, helps you sleep better and wake more rested, Prevention of angina, chest pains caused by decreased oxygen to the heart, Decreased your risk of sudden death from heart disease or stroke, Improved blood sugar levels. I understand that these risks may be modest if I am not significantly overweight but that these risks increase considerably the more overweight I am. I understand that appetite suppressants have been taken safely by millions of people, but as with any medications there is a possibility of side effects or an adverse reaction. Risks of this program may include but are not limited to common symptoms like Depression, Drowsiness, Increased blood pressure, Irritability. Less common to rare symptoms like Blurred vision, Confusion, Diarrhea, Dizziness, Dry mouth, Headache, Irregular Heartbeat, Vomiting, Stomach pain, Tiredness, Heart palpitations, Chest pain, Shortness of breath, Rapid weight loss may also be associated with some medical problems but not limited to physical such as dizziness, hair loss or gall bladder disease. The program provides medical supervision to minimize the risks associated with rapid weight loss.

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 understand the possible rare complications of SC/IM injection are abscess, cellulitis, tissue necrosis, granuloma, muscle fibrosis, contractures, hematoma and injury to blood vessels, bones and peripheral nerves.

I understand that appetite suppressants should not be used in conjunction with cocaine, caffeine, medicine for colds, fluoxetine, medicine for asthma or breathing problems, etc. I will inform my doctor of all prescriptions and over the counter medications I am taking.

I understand that children under the age of 17 and adults over the age of 65, pregnant, or breast feeding women, people with significant health problems like, heart disease, hypertension, cardiovascular disease, history of alcohol abuse, history of drug abuse, kidney disease, diabetes, psychiatric disorders, brain disease are NOT recommended to use appetite suppressants and should consult with their primary care doctors before participating in the program.

Prescription appetite suppressants are controlled drugs with significant regulations regarding their dispensing. I understand that once I receive a prescription for such medication, it will not be replaced or refilled except in compliance with regulations mandated by federal and state drug dispensing policies and guidelines. Once I leave the office with the controlled medication, I understand that I am fully responsible to comply with the usage of the drug as labeled. If I lose the prescription or the medication is accidentally disposed, I have no expectation of getting a new prescription without an office visit at an appropriate interval for a refill. There will be no exceptions to these restrictions.

The appetite suppressants Phentermine could cause the patient to have a positive drug test with amphetamines.

I understand that I, have to keep this and all medications out of children's reach, store away from heat or damp places and direct light, do NOT keep outdated medications past the expiration date.

***I understand that if a prescription for an appetite suppressant is issued that I can get it filled at an outside pharmacy of my choice, but I choose to get the prescription dispensed at Right Weight Clinics LLC as it is more convenient for me.***

By signing below, I acknowledge that I have read and fully understand this consent form, and I realize that 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 satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor and/or his staff regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

**Patient:** \_\_\_\_\_ **Patient name/Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_