Complete Health-Weight Loss Consent

Patient Name: ______________________________
Date of Birth:____________________
Phone No.:________________________________
Email Address: ______________________________

Emergency Contact:
Name: ___________________________________
Relation:__________________________
Phone No:______________________

Patient Consent To Treatment:

I, ___________________________ hereby authorize Teresa Rispoli, L.Ac, CFN, PhD. to provide health care to me, including but not limited to the treatment of my weight problem . This may involve but not be limited to history taking, in-office testing & physical examinations and/or additional laboratory testing.

I, ___________________________ hereby authorize Teresa Rispoli, L.Ac, CFN, PhD. to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, instruction in behavior modification techniques, and may involve the use of nutritional supplements. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that these supplements have been used safely & successfully in other health care practices for periods exceeding those recommended in the product literature.

(Please initial each paragraph. If you have any questions please feel free to ask the Dr. Rispoli)

________ I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs not supervised by a physician. I also understand that remaining overweight or obese puts me at greater risk for ill health. Some of the complications that may develop as a consequence of prolonged abnormal body weight are arthritis of the joints, especially weight-bearing joints such as hips, knees, feet and back, high cholesterol and triglycerides, high blood pressure, diabetes, vascular disease complicated by stroke, heart attack, and abnormal heart rhythms, gallstones, 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 success of weight management treatment depends on my active participation. Complete Health, Dr. Rispoli cannot guarantee or assure treatment success or any definite outcome. I understand that obesity is considered a chronic condition that may require permanent changes in my eating habits & behavior to attempt success at treatment.

________ I have read and fully understand this consent form & I realize I should not sign this form if all items have not been satisfactorily explained to me. With my signature I acknowledge that my questions have been answered fully, and that I have been requested to read this form and have been given ample time to understand all its contents.

________ I understand the Ha2CG 30 minute consultation and Maintenance consultation cost $95. all supplements, prescriptions and laboratory fees are excluded from this pricing.

________ I agree that I do not have any pre-existing conditions(described on the next page) that may affect my health while on a low calorie diet. Contraindications were explained to me and I agree I do not have any conditions that my adversely affect my weight loss care.

________ I understand that once I receive the weight-loss products there will be **no refunds**.

If at this time you have any questions regarding the risks or dangers of the proposed treatment, or would like further explanations concerning the proposed treatment or any alternative options, ask your healthcare provider now before signing this consent form.

Patient Name- Please Print	**Patient Signature**	**Date**

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Ha2CG sublingual: This is a natural hormone that directs the body to release and burn the fat out of the most stubborn areas such as thighs, stomach, arms etc.

There are no known negative side effects Ha2CG; however patients with certain medical conditions are excluded from participating in this program.

By **Initialing** below I certify that **I do not** have any of the following conditions:

- ______ Have gallbladder colic
- ______ Have a weak or compromised immune system
- ______ Have untreated graves' disease
- ______ Have brittle or hard to control diabetes
- ______ Have High blood pressure
- ______ Have Low blood pressure
- ______ Have History of Cancer
- ______ Women that are pregnant or breastfeeding
- ______ Have tuberculosis
- ______ Have unstable gout or angina
- _______ Have any Heart Problems or stroke
- _______ Have Blood Clotting or Blood Thinner Medication

Other Criteria to Ensure Positive Results:

- Follow dietary instruction and take supplements as recommended
- Maintain a daily food journal.
- Keep exercise to a **MINIMUM** to avoid increasing appetite.
- Following the transition as outlined by the guidelines is vital to maintain achieved results and/or to continue losing weight.
- If you want to continue with the Ha2CG Program for more than 45 days you **MUST WAIT 6 WEEKS** to let your body rest before starting another round.

Patient Name- Please Print	**Patient Signature**	**Date**