Michele Delzer, CNP

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PATIENT CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT

If you have any questions, please feel free to ask us. Please **initial each statement** below to acknowledge your understanding:

Financial Responsibility

_____ Services must be paid for at the time of service, or a payment plan must be arranged in advance.

_____ Health insurance typically does **not** cover services provided at RCHP. If you wish to seek reimbursement, RCHP can provide itemized invoices for you to submit to your insurance company.

Medication Use & Compliance

_____ I understand that **Phentermine and Vyvanse** are controlled substances. I agree to take medications only as prescribed, to follow my medical provider's instructions, and not to sell or share my prescriptions with anyone.

_____ I understand that having an appointment with RCHP does not guarantee a prescription for weight loss or other medications. Prescription decisions are made at the sole discretion of the provider.

Treatment Purpose & Safety

_____ I understand that treatments provided at RCHP may not be considered a medical necessity and are offered to improve quality of life through nutritional guidance, supplemental counseling, and weight loss treatment.

_____ If I experience side effects or become ill, I will follow up with my primary care provider or seek urgent/emergency care as appropriate.

_____ I acknowledge that RCHP and Michele Delzer are not my primary care provider unless I specifically elect them to be. I agree to continue routine care with my primary care provider and notify them of treatments prescribed at RCHP.

_____ I understand that there are **no refunds** for services or products rendered. Medications dispensed cannot be returned once they are opened or used, per state regulations.

_____ I understand that I must attend scheduled follow-up appointments and complete recommended lab work to remain on treatment. Ongoing treatment and prescriptions are provided at the discretion of Michele Delzer.

Risks, Benefits, and Limitations

_____ I acknowledge that I have been advised of the **risks, benefits, complications, and possible side effects** of weight loss treatment and understand them.

_____ I understand that I may request treatment for weight loss even if my weight falls within normal limits or if I am classified as overweight but not obese, and that treatment decisions will be made mutually between myself and the provider.

_____ I do not hold any practitioner at RCHP responsible for providing age-related preventive care. I agree to follow up with my primary care provider for preventive screenings and acknowledge that my treatment at RCHP may be adjusted based on those results.

I have read, understood, and agree to all the above statements.

Printed Name:

_____

Signature: _____ **Date:** _____