Weight Loss Consumer Bill of Rights

This document outlines the rights of consumers seeking professional weight-loss services.

Please read these rights below:

1) Warning: rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program.
2) Consult your personal physician before starting any weight-loss program.
3) Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long-term weight loss.
4) Qualifications of this provider are available upon request.

You have a right to:

1) Ask questions about the potential health risks of this program and its nutritional content, psychological support and educational components.
2) Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
3) Know the actual or estimated duration of the program.

Patient Informed Consent to Use Appetite Suppressants

Please carefully read the following statements. On the next page, please sign indicating your understanding and agreement.

1) **Procedures and Alternatives**
   a) I have read and understand each of the following statements: (i) All prescription medications, including appetite suppressants, have labeling approved by the Food and Drug Administration. This labeling contains suggestions of the use of the medication. Medications are prescribed only in accordance with recommended guidelines and evidence-based medicine. (ii) After consulting my provider, I believe that the probability of such side effects is outweighed by the potential benefit of the appetite suppressants being prescribed and/or provided to me.
   b) I understand that it is my responsibility to follow my provider's instructions carefully and to report any medical problems immediately, regardless of whether I think that they may be related to my weight control program. I further affirm that I am not now pregnant and will report any pregnancy to my physician immediately.
   c) I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain any weight loss. In particular, a balanced diet combined with physical exercise is recommended, with or without the use of appetite suppressants. I understand that a program including a revised diet and physical exercise could prove successful without appetite suppressants if I followed it.
2) **Risks of Proposed Treatment** - I understand that this authorization is given to me with the knowledge that the use of appetite suppressants poses various risks, including by not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medical allergies, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could occasionally be serious or even fatal.
3) **Risks Associated with Being Overweight or Obese** - I understand that remaining overweight or obese poses certain risks, among them being tendencies to high blood pressure, to diabetes, to heart attack and heart disease, to arthritis at the joints, hips, knees and feet, and to certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.
4) **No Guarantees** - I understand that much of the success of this program will depend on my efforts. Not with standing my efforts, I understand 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 my life if I am to be successful.

Patient's Consent

I have read and fully understand this consent form and I have had all concerns addressed by the provider. Moreover, I have been informed by my provider of the nature, risks, possible alternative treatments, possible consequences and possible complications involved in the use of appetite suppressants for the treatment of obesity and for weight loss. Nevertheless, I authorize my provider to administer such treatment to me.

Patient's Signature: _____ Patient's Printed Name: _____

Date of Birth: _____ Date: _____