I understand that my physician, based on his experience, the experience of his colleagues, and other factors, may recommend the use of medications for a period of time or at doses in excess of, or in uses outside of those recommended by the manufacturer's label. I further understand that such usage may not have been as systemically studied as that suggested by the labeling, and it is possible, as with many other medications, that serious side effects could occur.

After consulting my physician, I believe that the probability of such side effects is outweighed by the potential benefit of the medication being prescribed and/or provided to me, notwithstanding the fact that the dosage and/or term may exceed those recommended by the manufacturer.

I understand that it is my responsibility to follow my physician'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.

I understand that remaining overweight or obese poses certain risks, such as high blood pressure, diabetes, heart disease, cancer, and arthritis.

I understand that weekly attendance is a crucial component in achieving weight loss. (Patients who are absent from the program do not do well in their weight loss efforts, short term or long term, and are much more likely to drop out of the program.)

I understand that much of the success of this program will depend on my efforts. I understand that there are no guarantees that this or any program will be successful.

I understand that not attending a scheduled appointment, or contacting the weight loss staff to cancel a scheduled appointment, will be recorded as a "No Show" appointment. I further understand that excessive "No Show" appointments can lead to the forfeiture of the appointments in question, at my cost.

I have read and fully understand this consent form and I have had all concerns addressed by the medical staff. I have been informed by my physician of the risks and possible complications involved with the medications prescribed for this weight loss program for the treatment of obesity and weight loss. I authorize my physician to administer such treatment to me.

Patient's Signature:____ Date:_____________

Printed Name:____