LIFESTYLE
SOLUTIONS MEDSPA
BEAUTY THROUGH HEALTH

Weight Loss Program Consent Form

I, _____, (patient/guardian) do hereby authorize Dr. Holloway and staff, to assist me with weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may include the use of appetite suppressants and fat burning injections. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up and show continued weight loss.

Regarding the use of appetite suppressants, as with any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart rate. I understand that these and other risks could be serious or in rare cases life threatening. **Initial: _____**

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Lifestyle Solutions staff immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. **Initial: _____**

I agree not to take any other weight loss medications, other than those prescribed by Dr. Holloway and further agree to inform the staff of ANY changes in my medication or medical history. **Initial: _____**

I understand that I can be successful without the use of appetite suppressants or injections as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications and injections may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain of the joints, gallbladder disease and even sudden death. **Initial:_____**

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling and at times in larger doses. Dr. Holloway is not required to use the medications as the labeling suggests but does use it as a source of information along with his own experience, the experiences of his colleagues, as well as recent studies and recommendations of investigators and professional societies. **Initial: _____**

I understand that there is no guarantee that this program will work for me. I understand that I must follow the program as directed in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by my insurance and Lifestyle Solutions does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out. **Initial: _____**

By signing below I certify that I have read and fully understand this consent form and understand the risks and benefits associated with my treatment for weight loss.

Patient Signature: _____ **Date: _____**