NJ Gastroenterology Health and Wellness

CONSENT FOR MEDICAL WEIGHT LOSS TREATMENT

I, _____, (patient or guardian) authorize NJGHW (Dr. Matusow/Berberian) to assist me in weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise, and behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that in order to continue to receive these appetite suppressant medications, I must show continued weight loss.

Regarding the use of appetite suppressants, I understand that there are potential risks involved, though in general, minor, to include: nervousness, constipation, sleeplessness, headaches, dry mouth, tiredness, nausea, diarrhea, elevated blood pressure or heart rate, heart irregularities; however this list is not complete. We will provide you with information on the medication that you'll possibly be prescribed to give you more detail. Just because a potential side effect is listed, does not mean that you will experience them. I understand that there are potential risks of each medication potentially prescribed and accept those risks since the benefits outweigh any possible risk/s_____(initial).

I understand that if I develop side effects from the medication, I will discontinue taking it and notify Dr. Matusow/Berberian, immediately, and in the event it is more of a serious/severe problem, I will go right to the closest Emergency Room for immediate care.

I do not have a history of alcohol abuse, drug abuse, schizophrenia, bipolar disorder, eating disorder (anorexia or bulimia), since these conditions constitute a contraindication to the use of appetite suppressants. I also confirm that (if female), am not pregnant or will become pregnant during treatment_____(initial). I agree not to take any other weight loss medications, including over-the-counters, other than those prescribed by my doctor/s and further agree to inform the staff of Drs. Matusow/Berberian of ANY changes in my medication or medical history_____(initial).

I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of appetite suppressants would like prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, sleep apnea, stroke, arthritis of the joints, hips/knees/feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallstones/gallbladder disease_____(initial).

I understand that my bariatric physician/s have found appetite suppressants helpful for periods of time longer than those suggested in the medication labeling, and at times in larger doses that those suggested in the labeling (especially using Phentermine). Your weight loss physician is not required to use the medications as the labeling suggests but do use it as a source of information along with their own experience, recent studies, and recommendations of investigators. Based upon these, your physician may, when indicated, to use the appetite suppressants for longer periods of times and in increased doses. As a patient of Dr. Matusow/Berberian, I understand that I may be prescribed medications as stated above_____(initial).

There is no guarantee that this weight loss 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 insurance. I also understand no refunds are provided by the medical practice.

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

Patient:_____ Date:_____

Witness:_____