Treatment Consent Form for the LOSE FOR LIFE (LFL) Physician Supervised Weight Management Program

Authorization for Examination and Treatment

I am aware that I must meet medical and psychological screening criteria established by the LFL program of weight management professionals before entering the program.

I hereby authorize and consent to have the program physician perform physical and diagnostic procedures when necessary and appropriate.

I am aware that during the fasting period, possible side effects may occur from ketosis. These side effects include dizziness and fruity breath. Less common but possible side effects are fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea and constipation.

I have been informed that foot-drop is a rare transitory side effect of weight loss.

I have been informed that any weight loss regimen increases the chance of gallstone formation.

If medical complications unrelated to weight loss arise while I am on the program, I am fully aware I will be referred back to my private physician for treatment and evaluation.

I recognize that if I become pregnant while on the program, my participation must be terminated.

I understand that I will pay for products weekly and for other services as has been discussed with me.

The LOSE FOR LIFE team has answered my question regarding the program and possible side effects.

No guarantee has been given to me by anyone as to the results that may be obtained.

Having been explained the risks and benefits of the LOSE FOR LIFE program, a medically monitored program for safe and rapid weight loss and complete education to help manage weight. I knowingly and voluntarily desire to participate in the program.

Client Signature: _____ Date: _____

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