Only Choice Urgent Care
K & J Care Unit, LLC

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Weight Program Patient Agreement and Consent Form

I, _____, (print name) do hereby authorize the providers and staff at Only Choice Urgent Care, to assist me with weight loss. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may or may not include the use of appetite suppressants (Phentermine, Tenuate, etc.) and fat burning injections. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up visits **and** show continued weight loss every 30 days, no refills for this medication is given without an in office visit. (No phone or video consultations) **NO EXCEPTIONS.**

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. Our office/staff members are not responsible for any risks and/or adverse effects, infections, etc. that could happen after receiving an injection or having blood drawn.

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Only Choice 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 or other types of controlled medications, other than those discussed and/or prescribed by the provider at Only Choice Urgent Care. I further agree to inform the staff of ANY changes in my medication or medical history. I also understand that I will be checked in the Texas Prescription Monitoring Program (PMP) and the provider may also check my recent prescriptions filled during each visit to manage contraindications.

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.

I understand that studies have found appetite suppressants helpful for periods longer than those suggested in the medication labeling, after 12 weeks another health exam will be done before further prescriptions are prescribed if I have not reached a BMI less than 30.1.

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 whether I receive a prescription or not. I understand that these charges are not covered by my insurance and Only Choice does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out. I understand that if I need to be seen for anything other than weight related issues, I am to pay an additional office consultation fee or my co-pay for those services.

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 Name _____ DOB _____

Patient Signature _____ Date _____