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CARE
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Weight Loss/Injection Consent Form

I, _____, do hereby authorize RediCare 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.

Initial: _____

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 RediCare 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, severe tachycardia, 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 RediCare 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 (up to 12 weeks for certain stimulants), 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 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. RediCare does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out. Initial: _____

I give consent for RediCare to administer the fat burning vitamin/amino acid injections as discussed. I have read the information sheet and understand the risks and side effects of these injections. I also have been offered an opportunity to discuss this information, risks and side effects with a provider and have declined to do so. Initial: _____

Patient Name (print): _____

Patient Signature: _____

Date: _____