DR. BOB MEDICAL WEIGHT LOSS CENTER

PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I have requested and authorized **DR. BOB MEDICAL WEIGHT LOSS CENTER** to assist me in my weight reduction efforts. I understand that my treatment may involve, but not be limited to the use of appetite suppressants.

I understand that if after my initial consultation, I decided that I do not want to participate in the program, or should the physician/nurse practitioner determine that based on the exam the use of appetite suppressants is not indicated, I will not be eligible for a refund.

I understand it is my responsibility to follow all instructions carefully and to report to the provider treating me all medical problems or symptoms that I feel may be related to my weight control program as soon as they occur.

I understand that discontinuation of pharmacological agents may occur at any time under my health care providers discretion.

I acknowledge that in initiation therapy there are potential risks involved:

1. **Most common side effects include, but are not limited to: Nervousness, Over Stimulation, Restlessness, Dizziness, Headache, Dry Mouth, Anxiety, Changes in Mood, Rapid Heart Rate, and Medication Allergies (rash, hives).**
2. **Increased Blood Pressure.**
3. **Developing primary pulmonary hypertension.**
4. **Potential of causing birth defects.**
5. **Increased difficulty in controlling diabetes, hypertension, and other chronic diseases.**
6. **Developing Regurgitant Cardiac Valvular disease.**
7. **Adverse effects may occur with altering the dose or stopping my medications without first consulting my doctors.**

I have read and fully understand this consent form. I have had the opportunity to discuss any questions about my weight control program. My provider has answered all of my questions.

X_____ _____ _____

PATIENT SIGNATURE DATE TIME

_____ _____

WITNESS MEDICAL BOARD NUMBER