LEAN MD
MEDICALLY SUPPORTED WEIGHT LOSS

The Better Weigh Center | 5826 Esplanade Drive Suite 102 | Corpus Christi, TX 78414 | P: 361-500-2898

Patient Informed Consent for LeanMD Program

Patient Name: _____ Date of Birth: _____

This Informed Consent form is intended to give fair notice of the requirements of patients seeking to participate in the Lean MD, Inc. Weight Loss Program (Program) at **Better Weigh Center** ; to fully disclose risks associated with participation in the Program, and to obtain written "Informed Consent" from the patient to undergo treatment in the Program.

I. Procedures and Alternatives

1. I have read and understand that medications, including the appetite suppressants used in the Program, have labelling and instructions for use established by the Food and Drug Administration. This labelling contains, among other things, suggestions and advisals regarding quantity and interval of use. for using the medication.

   I understand that (a) you have found that, in your medical judgment and based upon your professional training, appetite suppressants are helpful for periods in excess of the 12-week period generally set forth on the labelling, and at times in larger doses than those indicated on the labelling; (b) as physicians, you are not required to use the medication as the labelling suggests, but do use the labelling as a source of information along with your own experience, the experience of your colleagues, long-term studies, and recommendations of university-based investigators; and (c) based on these, you have chosen, when indicated, to use the appetite suppressants for longer periods of time and, at times, in increased doses. I fully understand that it is my own decision to participate in the Program, and that part of the Program may involve the use of appetite suppressants; that I am free to request lower doses or doses at different intervals, or to refrain from any use of such medications; that I may stop at any time; and that if I have any side effects of concern,I should report those to my physicians. I further understand that I am free to consult with other health care professionals regarding this issue and am encouraged to do so.

2. I understand that my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labelling.

3. I understand that it is my responsibility to follow the instructions carefully and to report to the doctor treating me any significant medical problems that I think may be related to my Weight loss program as soon as is reasonably possible.

4. I understand that the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand that my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. 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 the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

6. I understand that it is my responsibility to follow instructions carefully and to report to the medical provider treating me for my weight any significant medical problems that I think may be related to my weight loss program as soon as possible. I will notify the medical provider as soon as possible if I am taking any anti-depressant, or if any other new medications are prescribed by any other providers, or if any new medical conditions or diagnoses arise during the course of my weight program.

7. I understand that if I have any chronic condition such as hypertension, cardiovascular disease, diabetes or other health issue, I will be required to monitor daily my vital signs (blood pressure and pulse) and possibly glucose readings and other requested items, depending on my specific health conditions. I will report this information to my LeanMD Mentor at my weekly visits.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labelling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication

allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common but more serious risks are primary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal. I further understand that the drugs I am likely to receive include controlled substances, which have an abuse and physical addiction potential. I further understand that, if I so desire, I am allowed to continue in the Program with or without using such medications without penalty.

III. Risks Associated with Being Overweight or Obese

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand that these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees

I understand that much of the success of the Program will depend on my efforts and that there are no guarantees or assurances that the Program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent

I have read and fully understand this consent form and I realize that I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor and others of my choosing regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I am aware of the potential risks, benefits, side effects and adverse reactions associated with the Program and I have had the opportunity to ask any questions.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the weight loss treatment, including the use of appetite suppressants along with diet and other therapies, with the associated risks.

VI. My Chronic Conditions and Home Monitoring Plan

- ❒ Hypertension: Record home blood pressure/pulse a minimum of every other day and bring to weekly weight checks.
- ❒ Diabetes – Record home glucose at least daily and blood pressure/pulse a minimum of every other day and bring to weekly weight checks.
- ❒ Heart/Cardiovascular Disease – Record home blood pressure/pulse a minimum of every other day and bring to weekly weight checks.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW, BEFORE SIGNING THIS CONSENT FORM.

Date **Time**

Patient Signature **Witness**

Medical Provider Declaration

I have explained the contents of this document to the patient and have answered all of the patient's related questions, and, to the best of my knowledge, I believe the patient has been adequately informed concerning the benefits and risks of the Program, including those associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies, and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

Medical Provider Signature **Date**