Versalo M.D. Weight Loss

Consent

I _____ authorize the designated physician at Versalo M.D. weight loss center to help me in my weight reduction efforts. I understand that the program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, and/ or protein supplements.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headache, dry mouth, gastrointestinal disturbance, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeats, and heart irregularities. These and other possible risks could on occasion be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart disease, arthritis, sleep apnea, cancer and sudden death. I understand that these risks may be modest if I am no significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantee or assurance that the program will be successful. I also understand that obesity may be a chronic life-long condition that may require changes in eating habits as well as behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign the form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any question regarding the risks or hazards of the proposed treatment, or any questions whatever concerning the proposed treatments, ask the doctor before signing this consent form.

_____ _____

Patient Name Date

_____

Patient/Guardian signature

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