slenderkare Weight Loss & Wellness Plan Consent Form

I ____ authorize Dr. William B. Drury and his designated staff, to assist me in my weight reduction efforts. I understand that my program will consist of a balanced calorie-restricted diet, a regular exercise program and instruction in behavior modification techniques, and it may involve the use of appetite suppressant medications as well as vitamin supplements. Other treatment options include a low caloric diet and/or a protein-supplemented diet. I am aware that if appetite suppressants are used, they may be used in doses and duration exceeding those recommended in the medication package insert. I am informed that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature. Furthermore, I acknowledge that while these medications do carry risks (noted below), it is believed that these risks are outweighed by the potential benefits of using these medications in a responsible and monitored manner to help suppress calorie intake.

Depending on the program best suited for me, scheduled LipoPlex injections may be included (weekly or bi-weekly). LipoPlex injections not utilized on schedule will be forfeited and cannot be accrued or saved for future use. NO EXCEPTIONS. The monthly all-inclusive program works as a whole and cannot be split up in any form. (Simply – if you run out of some medications before the end of the month or have some left over--You cannot purchase medications separately. You are more than welcome to participate in a "re-up" for an additional month. Again—unused LipoPlex injections—are forfeited).
Please be respectful of our research and the success of those on the program that follow the plan as prescribed. Thank you for understanding. We are excited for all our slenderkare clients that have lost and are losing weight and inches!

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, headaches, dry mouth, gastrointestinal disturbances, weakness, fatigue, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight include tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I realize that 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 know that it is my responsibility to follow instructions carefully and to report to the prescribing physician any adverse events that I think might be related to my weight control program as soon as reasonably possible. I understand that the purpose of the treatment plan is to assist me in my desire to lose weight and maintain this weight loss. The continued use and prescribing of the appetite suppressants will depend on my progress and success in weight reduction and maintenance. I also understand that obesity can be a chronic, lifelong condition requiring permanent changes in eating habits and behavior modification to be treated successfully.

Prescription Policies:
Prescription appetite suppressants are controlled drugs with significant regulations regarding their dispensing. I understand that once I receive a prescription for such medication from Dr. Drury or his office, it will not be replaced or refilled except in compliance with regulations mandated by federal and state drug dispensing policies and guidelines. Once I leave the office with the controlled medication, I understand that I am fully responsible to comply with the usage of the drug as labeled. If I lose the prescription or the medication is accidentally disposed, I have no expectation of getting a new prescription without an office visit at an appropriate interval for a refill. There will be no exceptions to these restrictions.

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 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/or his staff regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

*****If you have any questions regarding the risks 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: ________________________________ **Witness:** ________________________________
(Signature of patient or person with authority to consent for patient)