ENVISION
WEIGHT LOSS

Medical Program Treatment Consent Form

Authorization for Examination and Treatment

1. Having been explained the risks and benefits of the Medical Program a medically monitored program for rapid, safe* weight loss and complete education to help manage weight. I knowingly and voluntarily desire to participate in the Program.
2. I am aware that I must meet medical and psychological screening criteria established by the Medical team of weight management professionals before entering the Program.
3. I hereby authorize and consent to have Program physicians perform complete physical and diagnostic procedures including blood test, electrocardiogram (EKG), and possibly a stress test and/or chest radiography for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.
4. As part of the Medical Program, continuous medical monitoring is mandatory. Consequently, upon acceptance to the Program, I willingly agree to have this monitoring performed (blood tests, periodic EKG, and other tests as indicated).
5. I am aware during the weight loss period possible side effects may occur from ketosis. Ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). These side effects include dizziness and fruity breath. Less common, but possible side effects are fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea and constipation.
6. I have been informed that any weight loss regimen increases the chance of gallstone formation.
7. If medical complications unrelated to weight loss arise during the Program, I am fully aware I will be referred back to my private physician for treatment and evaluation.
8. I recognize that if I should become pregnant my participation in the (if applicable) Program must be terminated.
9. I understand that I will pay for my products and program services on a weekly basis. I understand that it is my responsibility to pay for these services.
10. The physician/nurse practitioner team of weight management professionals has answered my questions regarding this Program and possible side effects.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

**Physician monitoring is required to help minimize the potential for health risks.*

Acknowledgement of Envision Weight Loss Center
Practice Focus

_____ I understand that Dr. Krasner's focus of care is exclusively medical weight management and he will not address medical issues other than those associated with the treatment of overweight and obesity.

_____ I understand that I will be referred back to my primary care doctor to address any matters that do not pertain to medical weight management.

_____ I agree to notify my physicians that I am under the care of a bariatric physician to assist me with weight management. In the event that it is necessary to adjust medications, I will inform my doctors of what adjustments have been made.

_____ I give Envision Weight Loss permission to communicate with my doctors for the purpose of coordination of care.

_____ I understand that insurance companies are now recognizing obesity as a medical condition. However, not all insurances will pay for the treatment. I am responsible for all fees inquired, for services rendered, by my insurance. I am also responsible for payment of services at the time of each visit, if my insurance does not cover the program.

_____ I understand that all payments received are non-refundable.

_____ I understand that if I am treated for weight loss with prescription appetite suppressants I will only be given one month at a time and will need to be seen by the physician for any additional refills.

_____ I understand that there are no guarantees associated with my weight loss results. Each individual's needs are different and Envision Weight Loss will make every effort to modify the program as needed to ensure results.

Please initial that you have read and understand each of the objectives above.

Thank you.

ENVISION
WEIGHT LOSS

Patient Commitment Form

Commitment

Realizing that losing weight will require a great deal of time and effort on my part, I _____ _____ wish to participate in the Envision Weight Loss Program, a medically monitored program for weight loss and weight management of my health. I must maintain my weight loss once I reach my goal. Therefore, I am making the commitment to understand and practice the lifestyle changes presented in this program. If I find myself having difficulty, I will not hesitate to contact Dr. Krasner or Katlyn for assistance.

Involvement/Product

I agree to adhere to the program by being actively involved in the weekly office visits. I also agree to purchase and consume the amount of nutritional products prescribed to me, as they may be my sole source of nutrition. I also understand that once I have purchased the products they are not returnable.

I understand that the Program requires the following services to make my weight loss effective and safe:

- Medical screening before I enter the program.
- Routine visits with a physician (at least once monthly.)
- Weekly office visits that include information on behavior modification, nutrition education and exercise.
- I will follow prescribed meal plan and consume daily requirement of nutritional products.
- I agree to purchase all of my weekly prescribed protein product from your facility.
- Individual consultation about program-related issues that may be initiated by the staff or by me.
- Weekly medical monitoring of my weight, blood pressure and weekly compliance to the program.
- Periodic blood tests and EKG monitoring at regular weight loss intervals.

I have read all the above statements and understand their meaning. It is my wish to participate in the Envision Weight Loss Program under the conditions described.

Patient Signature: _____ Date: _____

ENVISION
WEIGHT LOSS

Appointment Policy

I, _____, hereby understand that I am agreeing to weekly visits and that my account will be charged to pay for the upcoming month in advance. If I miss any appointments during that month, I will not be entitled to more time added to my month or refund of the money paid. Envision Weight Loss will make every effort to allow me to change appointments within the week; however, I understand that availability may be limited.

My responsibilities have been fully explained to me. I understand that in consideration of other patients in the program and the physician, I will notify the office at least 24 hours in advance if I need to change my appointment failure to comply may result in being dismissed from the program. Although every effort is made to satisfy our patient's time requirements, multiple appointment slots for one patient are not available within the same week.

_____ _____

Patient Signature Date

Consent For Release of Medical Records

Obesity and being overweight is often the cause of many co-morbid conditions such as hypertension, hyperlipidemia, and type II diabetes. Studies have proven that a weight reduction of even 10% of your body weight decreases the risks of these conditions dramatically. While participating in our weight loss program, it is going to be very important that you work closely with Dr. Krasner and your primary care physician for treatment of these co-morbid conditions. If you are currently taking medications they will need to be adjusted as you lose weight. As your weight loss provider, it is important that this office focus only on your weight loss needs. We will not be treating you for any conditions other than weight loss at the time of your visit.

I understand that Dr. Krasner will not be treating me for any other condition that my weight loss needs and will at times refer me back to my primary care physician. I understand that is my responsibility to follow up with my doctor for any reduction in medication and any new conditions that I feel are not related to my weight loss. Furthermore, I give Dr. Krasner permission to share any of my medical weight loss information with my current doctor. If at any time my physician changes, I will notify this office of the change and ask that my records be updated accordingly.

_____ _____

Patient Signature Date

_____

Doctor's Name

_____

Address

_____

City, State & Zip Code

_____

Doctor's Phone Number