Royal Medical Health Inc.
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Weight Management Consent

I _____, DOB_____ understand,

The optimal management of overweight and obesity requires a combination of diet, exercise, and behavioral modification. In addition, some patients eventually require pharmacologic therapy or bariatric surgery. The choice of therapy is dependent on several factors including my clinician

_Maryam Bornaei _NP-C_decision, and the degree of my overweight or obesity. My risk of overweight will be evaluated before beginning any treatment program.

I understand an initial weight loss goal of 5 to 7 percent of body weight is realistic. A weight loss of 5 percent can reduce risk factors for cardiovascular disease, such as dyslipidemia, hypertension, and diabetes mellitus. The rate of weight loss is directly related to the difference between my energy intake and energy requirements.

I understand prediction of weight loss for me can be difficult because of my variability in initial body composition, adherence to program, and accurate report of my intake and energy expenditure. I understand the goals of treatment are to improve my quality of life and my health. I understand medication can be effective on treating my abnormal weight along with exercise, drinking less alcohol and quitting smoking and getting regular sleep. I understand which medicine my clinician picks depends on my health history. I understand I am responsible to keep my medication in a safe place and RMH will not be responsible for any medication lost or misuser. My clinician may not re-prescribe any extra medication. I understand that this procedure is cosmetic and that nonrefundable payment is due at the time of service. The fee schedule has been explained to me. Although the lab will be ordered before the program starts and it is necessary to have a result, I understands RMH is not responsible for any lab fees that I might receive.

I have acknowledged and signed all the necessary information about the medication I am receiving for weight loss management. I have understood and agreed with all the plans. I have asked all the questions I had for my medical weight management by RMH clinician. RMH has provided me with all the necessary information about the medication I may receive. I will seek medical attention if I have medication side effects. I will go to the emergency room in an urgent matter. I understand RMH will not be held financially responsible in any event.

I have been informed the specific medical information to be released/obtained and benefits/disadvantages of doing so has been explained to me. I give consent freely and voluntarily. Treatment services are not contingent upon whether this information is released. This consent authorizes RMH to release all information necessary and pertinent for funding purposes to be initiated and maintained throughout the treatment.

To the receiving party of information: this information has been disclosed to you for the sole purpose stated in this consent. Any other use is strictly prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to any treatment plan already released in response to this authorization. I understand that this revocation will not apply to my insurance company

I have read this form and understand what it means. I understand what the clinician has told me. I have had all questions and concerns answered by above clinician. All blanks were filled in before I signed the form. I understand and accept the risks of the plan.

Patient Signature_____Date_____