LAKE GROVE
FAMILY MEDICAL CLINIC

AGREEMENT AND CONSENT FOR WEIGHT MANAGEMENT

I authorize the healthcare team at Lake Grove Family Medical Clinic to participate in my weight management and fully understand and agree with the following statements:

1. Any medical treatment of obesity may have risks, benefits and side effects. There are also certain health risks associated with untreated obesity.

2. The use of anti-obesity medications is contra-indicated in certain medical conditions including pregnancy. Women in childbearing age should use an appropriate method of contraception to prevent pregnancy when using these drugs.

3. I will disclose the use of all the current medications that I am using to the medical team at the Lake Grove Family Medical Clinic. Failure to do this may cause drug interactions and related complications that can be serious and life threatening. I will also take the medication only as prescribed and will report any adverse reactions I experience to my healthcare team.

4. I will not sell, trade or share my medication with anyone else. I will not ask for duplicate prescriptions to different pharmacies. Doing so shall result in my discharge from the care at Lake Grove Family Medical Clinic.

5. Obesity is a lifelong disease. Successful management will depend upon my efforts in following the medical, nutritional and behavior recommendations.

6. Lake Grove Family Medical Clinic provides NO GUARANTEES for success of medical management of obesity. Based on periodic evaluations, my healthcare team may advise me to change or discontinue the use of anti-obesity medication.

7. I will remain under the care of my primary care physician for my general medical care.
   - Name of Primary Care Physician ____

8. I understand that a single prior authorization per dose increase will be attempted if I want to use my medical insurance. Lake Grove Family Medical Clinic will put forth its best efforts to get this approved. If the medication is denied, an appeal will not be attempted.

9. I will see my Provider monthly until I am at a maintenance dose. I am responsible for making and keeping these appointments.

10. I will not be provided with medication outside of an office encounter. I must be seen by my Provider in office to get a refill.

I have read and I fully understand this agreement and consent form. All my questions have been answered to my full satisfaction.

Patient Name: ____

Signature: _____________________________________Date: ______________________________________