



# Endocrine & Diabetes Center

Ali M. Safa, MD, FACP, FACE, ECNU & Associates

## AGREEMENT AND CONSENT FOR WEIGHT MANAGEMENT

I authorize the healthcare team of the Endocrine & Diabetes Center 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. Some anti-obesity medications are “controlled drugs” by law. I shall disclose its use to the members of my healthcare team and to any other physician or health care entity that I will encounter to avoid duplication or drug interactions.
4. I will disclose the use of all the current medications that I am using to the medical team at the Endocrine & Diabetes Center. 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.
5. 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 the Endocrine & Diabetes Center.
6. The use of some of the anti-obesity medications beyond 12 weeks is not approved by the U.S. Food and Drug Administration (FDA). My physician(s) at the Endocrine & Diabetes center may consider the use of these drugs “off label” for longer periods of time if appropriate.
7. Obesity is a lifelong disease. Successful management will depend upon my efforts in following the medical, nutritional and behavior recommendations.
8. Endocrine & Diabetes Center provides NO GUARANTEES for success of medical management of obesity. Based on periodic evaluation, my healthcare team may advise me to change or discontinue the use of anti-obesity medication.
9. I will remain under the care of my primary care physician for my general medical care.
10. I will be responsible for out-of-pocket expenses related to body composition analysis and nutritional coaching. Which will be discussed with me by the administrative staff. 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 \_\_\_\_\_

Witness’s name \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_