Weight Loss Coaching Program Consent Form

Program Details:

I am signing up for a 12-week medically managed weight loss coaching program which includes prescriptions for phentermine. Phentermine will be prescribed to me in 30-day supplies; it is not dispensed at the office. My BMI, vital signs, body measurements, lab work, and diet and exercise changes will all be checked at regular intervals.

I will receive a one-hour initial consult appointment, two monitoring appointments and a final program wrap-up appointment. Additionally, I will receive three scheduled phone calls from the provider to check my progress and answer questions. I will NOT be provided with a written diet but rather my current lifestyle, exercise regimen, and diet will be taken into consideration and my provider will help me find solutions to barriers I face for long term success.

I agree to participate in the weight loss coaching program at Gynecology Associates of North Georgia. I understand participation is voluntary. I will be responsible for the $800 program fee; my insurance company will not be charged for this lifestyle-coaching program. I will also be responsible for the cost of any labs, which are not covered by my insurance plan. Initial_____

I understand I will be prescribed a medication called phentermine as part of the program. I understand phentermine works best when coupled with responsible food choices and regular exercise. I will fill this medication at my pharmacy. My insurance may or may not cover the cost of phentermine.

Risks of taking phentermine include cardiac ischemia, pulmonary hypertension, dependency, increased blood pressure, restlessness, heart palpitations, euphoria, insomnia, dizziness, headache and GI upset. If I develop symptoms, which make it medically necessary to discontinue medication, I can either continue in the program without the medication or I may quit the program.

Payments I have made for services already delivered will not be refunded. If I prepaid for the program and have to quit due to medical reasons, I will be refunded a pro-rated portion of my payment. Initial_____

I understand I cannot take phentermine if I am pregnant or breastfeeding, taking certain antidepressant medications, have a history of cardiovascular disease, hyperthyroidism, glaucoma, or a history of drug or alcohol abuse. I will notify my provider of any changes in my health. Initial_____

I understand I must be seen in the office in order to receive phentermine refills, as my blood pressure must be monitored. Initial_____

Patient Name:_____Date of Birth: _____

Patient signature: _____