



CONSENT FORM

I _____ authorize David Thomas, M.D. of The Medical Spa @ GMG and his designated associate or assistants, to help me with my weight reduction efforts. I understand that the success of my weight loss depends upon my effort and there are no guarantees of weight loss or how long I will maintain any weight lost during the course of the weight management program. Obesity may be a chronic condition that may require permanent changes in behavior including dietary and exercise habits to be treated successfully.

My weight loss program may include a reduced calorie diet, exercise program, appetite suppressant medications and instruction in behavior modification. I understand that any weight loss regimen may involve risks as well as benefits. I also understand that there is significant health risks associated with being overweight or obese. Risks of the weight loss program may include but are not limited to fatigue, headaches, trouble sleeping, dry mouth, diarrhea, constipation, anxiety, depression, elevated blood pressure, heart irregularities/arrhythmias and very rarely death. Risks associated with remaining overweight or obese may include elevated blood pressure, diabetes, heart disease, heart attacks, arthritis, cancer, sleep apnea and sudden death.

My weight loss program may include FDA approved appetite suppressant medications. These medications may be used at doses higher than recommended in appetite suppressant labeling. These medications may also be given for longer periods of time than recommended by appetite suppressant labeling.

My weight loss program may include natural formulations and vitamin products which have not been evaluated by the FDA. In keeping with government regulations, we make no therapeutic or medical claims on these products.

I have read and fully understand this consent form. I realize that I should not sign the consent form if all items have not been explained to me. My questions have been answered to my complete satisfaction.

Date: _____

Patient: _____

(or person with authority to consent for patient)

Witness: _____