HAKSHA
HEALTHCARE S.C

www.hakshahealthcare.com

WEIGHT LOSS CONSENT FOR TREATMENT

Patient Name (*print name*):

I, the undersigned, hereby voluntarily consent for Haksha Healthcare S.C. (the "Practice"), through its principal, Dr. Kshama Keshava Bhat and its designated assistants, to help me in my weight management.

I understand that my program may consist of dietary education, exercise counseling, instruction in behavior modification techniques, and may involve the use of medications. Some of these medications are controlled substances, and I have consented to the use of them as part of my treatment plan.

I understand that any medical treatment may involve risks as well as the proposed benefits. I have been explained all the different benefits and risks involved in taking these medications, including certain serious and fatal risks. The medical recommendations maybe subject to change based on updated guidelines and evidence based practices. I also understand that there are certain health risks associated with elevated body mass index.

The Practice may provide me with gym equipment, workshops in diet and nutrition, workshops in exercise methods, and it is completely my responsibility to use these options at my own risk. The owner/Physician/staff and Haksha Healthcare S.C employees are not responsible for any damage from using the equipment.

In order to manage my weight in the best possible manner, I understand that I may need to provide medical records from my primary care provider and other providers. I may need additional blood work and work up, as deemed necessary by the medical team, for my safe treatment. This may include evaluation of sleep apnea, metabolic syndrome management, etc. based on case by case presentation. Neither the Practice nor its team is responsible for wrong/incorrect/inaccurate information provided to them.

Weight management financial coverage varies with each insurance, and it is my responsibility to discuss about my financial responsibilities with my insurance, before and while getting treated at the Practice. Neither the Practice nor any of its team members are responsible for any financial coverage decisions made by the insurance.

I understand that much of the success of the program will depend on my efforts, and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior and lifestyle changes, otherwise I understand I may regain all the additional weight again.

I also understand that there are other ways and programs that can assist in decreasing body weight and to maintain weight loss without the use of the appetite suppressant/other medications (if followed), though I would probably be hungrier without the appetite suppressants/other medications and the optimal weight loss may not be achieved.

I understand that if I do not adhere to the program guidelines as recommended by the Practice and its team, the Practice may elect to discharge me from the program. It is also important that any patient of the Practice conduct themselves appropriately at all times while interacting with the Practice and its team members. The Practice reserves the right to discharge a patient for inappropriate and/or abusive behavior. Also, any patient who is a "no show" for his/her appointment (i.e. does not appear for the appointment without the required advanced notice and/or good cause) more than three (3) times may also be discharged, if deemed appropriate by the Practice. In addition, the Practice reserves the right to make changes to their services, and weight management program or terminate the program at any time and from time to time.

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WEIGHT LOSS CONSENT FOR TREATMENT – CONTINUED

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and given all the time I need to read and understand this form. I also acknowledge that I have read and understood my rights completely.

With the current COVID-19 pandemic, I have voluntarily decided to seek treatment, and come in person to Haksha Healthcare for evaluation and treatment. I understand that by doing so, there is certainly risk of getting exposed to COVID-19 infection, and I have opted for in person treatment at this time. I have provided my complete consent for medical treatment by the Practice and its team members.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient Signature (*or legal guardian, please identify below)*:	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation:
Witness Signature:	Date:

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Patient Informed Consent for Appetite Suppressants

Patient Name (*print name - person authorizing*):

Procedure and Alternatives:

- I authorize Haksha Healthcare S.C. (the "Practice"), through its principal, Dr. Kshama Keshava Bhat and its designated assistants, to assist me in my weight management efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks, and that I have understood all the risks and benefits, including fatal risks of use of such medications and the duration of treatment.

- **I have read and understand my doctor's statements that follow:**

  Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The Practice and its team members are not responsible for any manufacturing/ingredient changes, and other individualistic pharmacologic parameters for each medication and its manufacturer.

- I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. **I will notify the physician if I am taking any anti-depressant medications, any mood or other behavioral changes. Some of these medications may cause suicidal ideation and or homicidal ideation and I understand significance of these risks associated with the medications and opt to proceed with using the medication.**

- I understand the purpose of this treatment is to assist me in my desire to get to a better, healthier weight in a safe manner. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance, and side effects and associated symptoms. If the Practice or any of its team members feel the medication may not be safe for a particular patient, they will discuss other options with me for my safety.

- I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

- **Risks of Proposed Treatment:**

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks involves some risk and hazards. The more common include nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

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Patient Informed Consent for Appetite Suppressants (Continued)

Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with elevated body mass index. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees.

I also understand that as I start to lose weight, I may need changes in other medications for optimal and safe weight management and prevention of serious complications. It is my responsibility to update all my healthcare team members about my medications.

No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful.

Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, **ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.**

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation:

PHYSICIAN DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of elevated body mass index. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician Signature:	Date: