Rainier Medical Weight Loss Informed Consent Form

I ______________________________________ authorize Dr. Valerie Sutherland, MD and whomever she designates as her assistants, to help me in my weight reduction efforts. I understand that my program may consist of a very low calorie diet using medical foods, a regular exercise program, instruction in behavior modification techniques, and / or prescription medication. I further understand that medications may be used for durations exceeding those recommended in the medication package insert. I understand that medications may be used "off label" or for indications other than those approved by the FDA. I understand many insurance plans do not cover medications for weight management. I can check with my plan, or a prior authorization request form can be completed for an out of pocket fee, although this will not change the terms of my insurance plan.

I understand that any medical treatment may involve risks as well as the proposed benefits. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, low blood pressure, low blood sugar, high blood sugar, gallstones, gout, and heart irregularities, heart attack, stroke or death. These and other possible risks could, on occasion, be serious or even fatal.

I understand that alcohol and recreational drugs are not recommended and are expected to increase the risks of medical weight loss. I understand that if the risks of the treatment are deemed to outweigh the benefit, my plan may be modified or terminated if deemed medically appropriate by Dr. Sutherland. I understand I need to attend follow up visits which are typically weekly for 12 weeks and 22 in the first 12 months unless arrangements are made in advance for exceptions like travel.

I understand that a very low calorie diet / protein sparing modified fast is a medical protocol, the safety and reliability of which depends on using medical foods that are fortified. In order to make your treatment as safe and predictable as possible, I understand I am required to use either the medical foods supplied by Rainier Medical or grocery store food and keep a food diary. I will not use commercial or other products to attempt to mimic the program while under Dr. Sutherland's care.

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 overweight/obesity is typically a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I understand that weight recurrence is expected and ongoing treatment, care, or measures are required to reduce the risk of weight regain. I understand Dr. Sutherland is not my primary care physician and it is recommended I maintain regular health screenings and follow up with my primary care provider.

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.

Patient Signature:__________________________________ Date: _______________

Printed Name: ____________________________________ DOB: ________________