RAINIERMEDICAL
weight loss • wellness

COMMITTMENT FORM

Realizing that losing weight will require a great deal of time and effort on my part, I wish to participate in the Rainier Medical Weight Loss and Wellness Program, a medically monitored program for weight loss and weight control. I must meet medical and psychological screening criteria established by the Rainier Medical Team of weight loss management professionals before entering the program. If medical complications unrelated to weight loss arise during the program I will be referred back to my primary care provider.

My goal is to lose weight and to keep it off and I have been informed that weight regain will occur if specific and consistent measures are not taken to prevent it. I agree to participate in and complete all phases of the program—Active Weight Loss, Transition and Maintenance.

I will attend recommended follow up visits at all phase of the program and will notify the staff in advance when I am unable to attend. I realize that if I miss more than two sessions without prior arrangements, I can be discharged from the program. I also realize that I have the option of leaving the program at any time but I will be responsible for adhering to the practice's No Show/Late Cancellation policy. I also understand that once I leave, there may be a waiting period before I can re-enter and may not be permitted to participate in the full medical protocol but may be permitted to follow a modified protocol which is expected to result in slower weight loss.

I understand that in the interest of my health, I must maintain my weight loss once I reach my goal. Therefore, I am making the commitment to understand and practice the lifestyle changes presented in this program. If I find weight regain is occurring, I will contact the office of Rainier Medical Weight Loss & Wellness for a follow up appointment.

I agree to adhere to the Rainier Medical Weight Loss and Wellness Program by being actively involved in the weekly follow up visits. I also agree to purchase and consume the amount of the New Direction Nutritional Products prescribed to me, acknowledging that the safety and efficacy in the both the short term and long term are affected by my adherence to protocol. I understand that commercially available products are not an acceptable replacement. I understand that the products are my sole source of nutrition unless I am on a modified plan which includes one meal a day of table food. Once I have purchased the medical food, it is not returnable. I realize that if I am not complying with the program, I can be discharged.

I understand that the following are expectations of participants in the Rainier Medical Program for safety and efficacy, acknowledging not all risk can be eliminated and results can vary:

- Complete Enrollment Application, initial blood work, and New Start Visit.
- Pay non refundable, one-time enrollment fee.
- Attend coaching visits weekly during the Active Weight Loss phase, every 2 weeks during Transition Phase, and monthly for 2 years on Maintenance Phase.
- Utilize New Direction Meal Replacement Products and not a commercially available product. The quality, safety, and efficacy can not be known of other products.
- Monitor my blood pressure at home if I have high blood pressure and my blood sugar if I have diabetes and alert the staff of any abnormalities.
- Communicate immediately any concerns I have with my program, my care, how I am feeling or how my body is responding.
- Obtain monthly blood tests at a Laboratories Northwest Laboratory within the week prior to my provider visit. If I choose to use a different lab, I will hand carry the lab order slip with me to get them drawn and make a follow up appointment with a provider to review the results.
- Schedule my provider visits so any program related prescription renewals are obtained during an office visit for optimal care. Follow up visits are typically conducted by a Physician Assistant - Certified.
- Sign up for MyChart and read any incoming message from the office unless there is some impediment to doing so, in which case I will inform the staff and call the office if I am unable to open a message.
- Obtain monthly Body Composition Analysis with an out of pocket cost of $45, having been advised this is important for assessment of the appropriateness of my plan.

I have read all the above statements and understand their meaning. It is my wish to participate in the Rainier Medical Program under the conditions described. I understand that if the medical recommendations are not fulfilled for any reason, my program may need to be modified or stopped.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____