

# Weight Loss Surgery Agreement

Weight Loss Surgery is an elective surgery. The surgery is intended to reduce medical conditions and improve the quality of life for those individuals who choose to have the surgery. Weight loss after weight loss surgery is greater when the patient understands the procedure. A greater understanding from the patient has shown to be a motivating factor in their desire to adhere to the pre and post operative responsibilities necessary for successful weight loss. It is important for each individual to understand the process involved and the responsibility that both the patient and the healthcare provider share to make this entire process successful. Please initial beside each statement to attest your understanding and compliance.

\_\_\_\_\_ I agree to attend the weight loss surgery information session prior to my surgery. These sessions are approximately 2 hours in length. Weight loss surgery is major surgery. While this surgery can be very successful, it is important that I understand it is a team effort between the patient and the group of health care providers that work to make this a successful and meaningful transition in my life. This session will also help me understand the procedure, in addition to the risks and benefits of surgery.

\_\_\_\_\_ I understand that nutrition is an important part of the success of my surgery. I agree to meet with the nutritionist.

\_\_\_\_\_ I understand that exercise is an important part of losing and maintaining a healthy weight. As I lose weight, it is important to maintain muscle to continue a healthy metabolism. I agree to meet with the fitness trainer and develop an exercise routine as part of my process of losing weight.

\_\_\_\_\_ I understand the importance and requirement of the psychological consultation prior to surgery. I understand that this may not be covered by insurance. I agree to this consultation.

\_\_\_\_\_ I understand that most insurance companies require that any testing, for authorization purposes, be current within the year prior to surgery. I understand that there is the possibility that if testing is not completed within a year, this may affect the authorization process.

\_\_\_\_\_ I understand that smoking disqualifies patients from surgery, because it not only interferes with wound healing and causes respiratory complications, but counteracts all the medical benefits of weight loss. Therefore, I agree that I am a nonsmoker, or agree to stop smoking 3 months prior to my surgery.

\_\_\_\_\_ I agree to attend one support group meeting prior to my surgery. I understand that talking with others who have had the surgery may be beneficial to my success.

\_\_\_\_\_ I agree to the use of any data in my chart for research purposes. Any information used will be strictly confidential. This data enables us to address ways to focus on the success of the program.

\_\_\_\_\_ I understand that to be accepted as a candidate for weight loss surgery, I must have a BMI between 35-55. The success of my surgery is enhanced by maintaining a BMI of less than 55. I understand that if my BMI becomes elevated beyond 55, that I jeopardize my surgery date and that my surgery will be cancelled.

\_\_\_\_\_ I understand that I must have a sincere motivation to lose weight. This motivation includes a willingness to make necessary changes in habits, to cooperate fully with instructions, and to keep appointments for follow-up visits. I can expect to be seen 2 weeks following surgery, 6 weeks, 3 months, 6 months, 12 months, and yearly. Failure to keep these appointments will result in my discharge from the program.

\_\_\_\_\_ I understand that gastric bypass decreases the absorption of nutrients and vitamins (malabsorptive procedure). A small pouch is created and part of my small bowel is bypassed. To prevent complications from malabsorption, I will have to take vitamin supplements the rest of my life. If I choose gastric banding surgery, I understand that I will have to take vitamin supplements the rest of my life.

\_\_\_\_\_ I understand that it is not a guarantee that reconstructive plastic surgery for excess skin will be covered by my insurance provider. I understand that if I should need reconstructive plastic surgery a separate request to my insurance provider will be required.

\_\_\_\_\_ I understand that it is against medical recommendation to become pregnant within 12 months of weight loss surgery. I understand that pregnancy within 12 months of weight loss surgery presents possible complications.

\_\_\_\_\_ I agree to pay a program fee at my initial office visit.

\_\_\_\_\_  
Patient Signature/Date

\_\_\_\_\_  
Witness/Date



**Carolinas Weight Management  
& Wellness Center  
Bariatric Agreement**

## Patient Information or Sticker

Name:  
DOB:  
Medical Record #:

Job CL3460  
Proof #2  
Ink: Black  
Paper: 20# White  
Date: 11/30/07