



Carolinas Weight Management & Wellness Center

Medical Program Agreement

Obesity affects all aspects of health including medical, emotional and psychological well being. The medical program's intent is to address all of these areas through an individualized health-care directed approach. It is important for each individual to understand the process and to appreciate the joint 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.

_____ I agree to attend and participate in all of my appointments at the center. 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.

_____ I understand that nutrition plays an important role in my success. I agree to meet and counsel with the dietitian as directed by my health care provider.

_____ 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 as directed by my health care provider.

_____ I understand that emotional well being impacts my weight loss efforts. I understand that I may be asked to complete a psychological evaluation to enhance my success. I understand this may include individual consultation and/or group participation.

_____ I understand that smoking counteracts all of the medical benefits of weight loss. Therefore, I agree that if I am a smoker, that I will work toward smoking cessation.

_____ 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 for follow up visits as designated by the health care provider. Failure to keep these appointments can result in my discharge from the program.

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

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

Patient Signature/Date

Witness Signature/Date