In HIS Image Day Spa, LLC

Patient Informed Consent for Weight Loss Program

1. I, (patient), am voluntarily enrolling in/or have enrolled in an aggressive weight management program through In HIS Image Day Spa, LLC. I hereby authorize Dr. Amy Holland or whomever she designates as her assistants , to provide medical care for me to assist in my weight reduction efforts, to achieve the goals of weight loss and weight maintenance. I Understand that such care may include but is not limited to physical/emotional health evaluations, referral for laboratory screening if needed, follow-ups with ongoing measurements of percent body fat, blood pressure, and weight, direct phone calls, instruction i behavior modification techniques, nutritional counseling, activities counseling, vitamin supplementation, and may involve the use of 1or more weight loss injectables, sublingual formulations, as well as appetite suppressants. As weight loss medications are recommended, all risks and benefits will be reviewed and I may ask questions to further understand all choices. Therefore, once I accept a course of treatment I am acknowledging my informed consent.

2. I understand it is my responsibility to follow any and all 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.

3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss.

4. I am aware that there are certain risks associated with remaining overweight. Among them are tendencies to high blood pressure, diabetes, heart attack, heart disease, and to arthritis of joints, hips, knees and feet, and many other disease states. Obesity also reduces my overall life expectancy. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am. I recognize these current risks to my health as unacceptable and wish to aggressively treat my weight by enrolling in this program.

5. No Guarantee: 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.

6. Patient's Consent:
I have read and fully understand this consent form and I am signing this form as all items have been explained or any question I have concerning them have been answered to my satisfaction. I have taken the time to read and understand this form and in discussing it with my doctor regarding risks associated with the proposed treatment and regarding all possible injectables, sublingual, pellet, or pill formulations that may be utilized to achieve my goal weight.

Date: Time:

Patient signature: Witness signature: