PHYSICIAN'S CHOICE WELLNESS, LLC

Treatment Consent Form

AUTHORIZATION FOR EXAMINATION AND TREATMENT

1. I have had explained to me the risks and benefits of the Physician's Choice Wellness Weight Management Program. I understand it is a medically monitored program for rapid, safe weight loss and complete education to help with weight maintenance. I knowingly and voluntarily desire to participate in the program.

2. I am aware that I must meet medical and psychological screening criteria established by the Physician's Choice Wellness team of weight management professionals before entering the program.

3. I hereby authorize and consent to have Physician's Choice Wellness physicians perform complete physical, and diagnostic procedures including blood tests, electrocardiogram ("EKG"), and possibly a stress test and/or chest radiography for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.

4. As part of the Physician's Choice Wellness program continuous medical monitoring is mandatory. Consequently, upon acceptance to the program, I willingly agree to have this monitoring performed (blood tests, periodic EKG, and other tests as indicated).

5. I am aware that during the fasting period possible side effects may occur from ketosis. These side effects have been explained to me, and I have had opportunity to ask any questions regarding these effects.

6. I have been informed that any weight loss regimen increases the chance of gallstone formation.

7. If medical complications unrelated to weight loss arise during the program, I am fully aware I will be referred back to my primary care physician for treatment and evaluation.

8. I recognize that if I should become pregnant my participation in the Physician's Choice Wellness program must be terminated.

9. I understand that I will pay for my Products and program services on a weekly basis. I understand that it is my responsibility to pay for these services myself, but that proper information will be provided so that I may file the billable charges with my medical insurance. I understand I am fully responsible for payment of the entire charges AT THE TIME they are received regardless of whether I have or believe I have insurance coverage, which would apply.

10. No guarantee has been given to me by anyone as to the results that may be obtained.

11. Having been advised of the above, I authorize and consent to the performance of the procedures and other treatment of the program.

12. ☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature of frequent visits of a weight loss program and may be copied upon request.)

Physician monitoring is required to help minimize the potential for health risks. VLCD participants will be seen MONTHLY, and LCD participants will be seen BIMONTHLY during the entire reducing phase. It is my (participant's) responsibility to make sure these appointments are scheduled and attended on a regular and routine basis.

_____		_____	
Participant	Date	PCW Team Member	Date