

Patient Acknowledgement of Cautionary Statement

I agree to complete a comprehensive history form that will be reviewed by our staff and the treating physician, Dr. Sheila L. Patterson. I agree to disclose any past or current medical conditions or problems that may exist or would be consistent with any of the conditions or problems in the cautionary statement. I have read and I understand that the conditions and contraindications that are outlined in the cautionary statement. I further understand that I will be given ample opportunity to ask the treating physician, Dr. Sheila L. Patterson, about any possible prescription medications that may be used in my care for weight management along with any potential side effects of such medications.

I also agree to notify this office of any potential adverse side effects that may occur following the use of any appetite prescription medications that may be prescribed. I agree that I will not consume alcohol or other contraindicated drugs while using any appetite suppressants as prescribed by this office. I further understand that upon withdrawal from this program, I will not be entitled to a refund of any previously paid monies.

Patient's Signature

Patient's Printed Name

Sheila L. Patterson, M.D.

____/____/____
Date