Jacqueline Mauer, FNP

NURSE PRACTITIONER

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Patient Consent Form

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____

Program Overview

You have chosen to participate in a medically supervised weight loss program under the guidance of Mauer Medical. This program may include nutritional counseling, lifestyle modifications, physical activity recommendations, and prescription medications or other weight management treatments as determined by your provider.

Potential Benefits

Participating in this weight loss program can lead to improved weight management, helping individuals achieve and maintain a healthier body weight. By making necessary lifestyle changes and adhering to medical guidance, participants may experience enhanced overall health and well-being. Additionally, successful weight loss can contribute to a reduced risk of developing weight-related conditions such as diabetes, hypertension, and heart disease. Many individuals also report increased energy levels and improved mobility, which can positively impact daily activities and overall quality of life.

Potential Risks & Side Effects

As with any medical treatment, there are potential risks and side effects associated with this weight loss program, including but not limited to:

- Nausea, vomiting, diarrhea, or constipation
- Dizziness or fatigue
- Low blood sugar (if applicable)
- Injection site reactions (if applicable)
- Possible allergic reactions or adverse effects

- Nervousness, sleeplessness, headaches
- Electrolyte abnormalities
- Dry mouth, gastrointestinal disturbances
- Weakness, fatigue, pancreatitis
- Psychological problems, gallstones
- High blood pressure, rapid or slowed heart rate, and heart irregularities
- Risk of weight regain

These risks are usually temporary, reversible, and manageable under medical supervision.

Patient Responsibilities

By signing this consent form, I acknowledge and agree to:

- Follow the treatment plan and dosing schedule as prescribed by my provider.
- Attend scheduled follow-up visits and communicate any side effects or concerns.
- Maintain an appropriate diet and exercise regimen as advised.
- Inform my healthcare provider of any changes in my medical history, medications, or health status.
- Understand that weight loss results may vary and are not guaranteed.

Legal Disclosures (Texas Compliance)

- Informed Consent: I acknowledge that I have been informed of the potential risks and benefits of this program, including alternative treatment options, and have had the opportunity to discuss them with my provider.
- Duration of Validity: This consent remains valid for the duration of my participation in the weight loss program unless revoked in writing.
- Communication Assistance: I confirm that I have received this information in a manner that I understand, with accommodations made if necessary due to disability or language barriers.
- Verbal Consent (if applicable): If I am participating in telemedicine consultations, I understand that verbal consent will be documented and treated as legally binding.
- Off-Label Medication Use: I acknowledge that some medications prescribed in this program may be used off-label for weight management, and I have been informed of the risks and benefits associated with such use.
- Right to Withdraw Consent: I understand that I have the right to withdraw from this program at any time without penalty.

Statement of Understanding

I understand the risks and benefits associated with this weight loss program, as well as the potential side effects outlined above. I acknowledge that the risks are generally temporary and reversible. I have had the opportunity to discuss these risks and benefits with my healthcare provider and have had my questions answered to my satisfaction.

If I am a female patient, I confirm that I am not pregnant and do not plan on becoming pregnant while taking prescribed weight loss medication. I understand that taking such medication while pregnant may pose risks to my health and the health of an unborn child.

Acknowledgment & Consent

I acknowledge that I have had the opportunity to discuss this weight loss program with my healthcare provider. I understand the potential risks, benefits, and alternatives associated with this treatment and have had my questions answered to my satisfaction. I voluntarily agree to participate in this program and consent to treatment as outlined above.

Patient Signature: _____
Date: _____

Provider Signature: _____
Date: _____