AtLast Medical Weight Loss
MEDICAL ASSOCIATES OF THE SHOALS, P.C.

Patient Participation Agreement

Patient Name:	Date of Birth:

1. I authorize the AtLast Medical Weight Loss Program to assist me in my weight reduction efforts.
2. I certify that the information I have provided is true and correct to the best of my knowledge.
3. I understand the purpose of this program is to assist me in my desire to decrease and maintain my body weight.
4. I understand my continuing to receive treatment will be dependent on my compliance, progress in weight reduction, and weight maintenance.
5. I am aware that there are certain risks associated with remaining overweight or obese. Risks include high blood pressure, diabetes, heart attack, arthritis, etc. The risks increase the more overweight I am.
6. I understand that much of the success of the program will depend on my own efforts and that there are no guarantees or assurances that the program will be successful.
7. I understand that I will have to make permanent lifestyle changes and monitor my weight my entire life in order to maintain success.
8. I understand my treatment may involve, but not be limited to, the use of appetite suppressants. I will discontinue the diet and/or medication and notify the program if I develop side effects from the diet and/or medication. I also understand if the problem is severe or worrisome, I will go to the nearest Emergency Room or see my primary care physician as soon as possible.
9. I understand that if I break this agreement, my doctor will cease treatment, and I may be dismissed from the program.
10. I agree that refills of my prescriptions will be made only at the time of an office visit or during regular office hours. No prescriptions will be refilled early. Prescriptions will be written for a maximum 30-day supply.
11. I agree not to take any other appetite suppressants, other medications, or injections other than those listed on the documentation I have completed for the program. I agree to inform the program of any updates or changes.
12. I will not attempt to obtain any weight loss medications from any other doctor or health care provider.
13. I will safeguard any prescriptions from loss or theft. Lost or stolen medicines will not be replaced.
14. I will keep all scheduled appointments. I realize that three or more missed appointments or cancellations may lead to my dismissal.
15. I understand it is my responsibility to follow the instructions carefully and to report to the provider, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
16. I understand that by joining this program I am agreeing to follow the recommended weight loss program and attend regular visits and consultations as required.
17. I understand that these services are not reimbursed by insurance and that the program will not complete claim forms for insurance purposes and that no refunds are given at any time for any reason.
18. I understand that I am responsible for full payment at the time of each visit. I agree that should my account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs.
19. **If I am a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking medications for weight loss. If I become pregnant, I will stop the medication immediately and notify the program immediately.**
20. **I have read and agree to comply with this participation agreement.**
21. **I hereby authorize AtLast Medical Weight Loss Program staff to take my photograph during my initial consultation, during treatment, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and they will be kept in my medical record at all times unless the program obtains additional consent for marketing purposes.**

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Patient Signature Date