Bariatric Associates of New England, LLC™

A Nutrition, Preventive Medicine & Weight Management Practice ™

Patient Consent for Treatment Form

I_____ authorize Dr. Tafuri and whomever he designates as his assistants/ supporting clinicians, to assist me in my preventive medical care/ weight management. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a low calorie protein supplemented diet.

I understand that any medical treatment may involve risks as well as the proposed benefits. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. I also understand that there are certain health risks associated with remaining overweight or obese, these risks include tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I also understand that this program may consist of a low calorie or very low calorie diet including the use of **high quality protein meal replacements and nutritionals**. These meal replacements and nutritionals prescribed through Bariatric Associates are monitored for consistent quality and effectiveness. **These meal replacements, if recommended for your specific weight management program, must be purchased from Bariatric Associates directly or through our online store at www.banellc.com. Patients not complying with this office policy will not be allowed to continue in our medical programs**.

I have read and fully understand this consent form. My questions have been answered to my complete satisfaction. I have been given all the time I need to read and understand this form.

- **All Program Fees, Co-pays, Meal Replacements & Nutraceuticals are Non Refundable**

  _____(pt initial)

DATE:_____ TIME:_____

WITNESS:_____ PATIENT:_____