LAROCCA
MEDICAL WEIGHT LOSS

Kristine D. LaRocca, D.O.
LaRocca Medical Weight Loss
Office: (302) 468-6220 | Fax: (877) 370-4281
20 Montchanin Rd., Suite 125, Greenville, DE 19807
kristine@doctorlarocca.com | DoctorLaRocca.com

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize Dr. Kristine D. LaRocca and associated healthcare providers, to help me in my weight-reduction efforts. I understand that my program may consist of a low carb diet, whole foods diet, intermittent fasting, increase in physical activity, instruction on behavior modification, and the use of anti-obesity medications.

I understand that any medical treatment may involve risks as well as benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks associated with obesity management programs are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and other heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with having obesity may include but are not limited to: high blood pressure; diabetes; heart attack; heart disease; cancer; arthritis of the joints, including hips, knees, feet, and back; sleep apnea; and sudden death. I understand that these risks may 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 that my plan will be successful. I also understand that obesity is a chronic, lifelong condition that will require permanent changes in eating habits, activity level, and behavior to be effective.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Witness

_____ _____

Patient Signature Date
(or signature of person with authority to consent for patient)