(Insert Facility/Physician Name & address)

CONSENT FOR WEIGHT LOSS PROGRAM

- I, _____ request from (insert facility/physician) to prescribe for me Human Chorionic Gonadotropin (HCG).
- I understand that HCG is not specifically approved by the FDA for preventive medicine and my request for HCG is off-label.
- I understand that the medical literature indicates that there may be health benefits to low calorie diet, HCG and appetite suppressant medication and its long-term effects are undetermined.
- I understand that (insert facility/physician) cannot guarantee any results or that there will be no harm. The potential health risks and benefits of using HCG and appetite suppressants have been explained to me to my satisfaction.
- I understand and I commit to modify my behaviors and write a daily food intake and exercise log.
- I understand that HCG is purely elective and that it may not be deemed medically necessary by insurance companies.
- I certify that I have read the above consent and fully understand it. I believe that I have adequate knowledge upon which to base this HCG informed consent.
- I fully understand what I am signing and hereby request and consent to HCG treatment.

Patient signature _____ Date _____

Physician signature _____ Date _____