

**GREAT LAKES WEIGHT AND WELLNESS
PATIENT RESPONSIBILITIES**

I UNDERSTAND THAT MY RESPONSIBILITIES AND OBLIGATIONS ARE AS FOLLOWS:

Program Information:

1. I must be willing to make participation in my program and the resulting long-term life-style changes a priority in my life.
2. I must be prompt in my clinic attendance each week. I understand that my time commitment for each weekly session is approximately 2 to 2 1/2 hours long, including the clinic visit and group sessions. I am expected to allow extra time on the weeks I have special tests or meetings scheduled.
3. I am expected to complete all assignments before each class. I understand that these assignments are an important aspect of my program, and will benefit me greatly. I have been informed that they take approximately 30 minutes each day.
4. I must attend group sessions each week. The sessions permit me to work on improving my eating and exercise habits and are an essential part of my treatment.
5. I agree to follow to the best of my ability the dietary and program protocols as outlined at the orientation session and as explained to me by the clinic staff.
6. I am required to notify the staff regarding any changes in my medications or other changes in my medical status.
7. If my program requires me to go below 1000 calories, I agree to adhere to the medical portion of this program. This includes seeing the program physician prior to entry and as scheduled during my program. Lab tests will be conducted prior to entry and bi-weekly according to program protocol.

Financial Information:

8. I understand that the program staff will provide me with all necessary documentation to complete my financial records. I may contact the program staff any time if I have questions or problems in this area.
9. If I choose to discontinue the program at any point, I must inform the staff before my next scheduled visit or I will be charged for that visit.
10. I agree to pay for each week of the program in accordance with the fee schedule agreed upon. Any additional medical visits, medical tests, supplement, and individual consultations with professional staff incurred throughout treatment will be billed separately.
11. I understand that, in general, supplies, maintenance, and nutritional supplements are not reimbursable by insurance. This program does not guarantee insurance reimbursement.
12. I understand that if I am absent I will be responsible for the charges for that week. I realize I will receive any materials and supplement not received due to an absence on the following visit.

Patient Signature

Date

Witness

Date