UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Metabolism, Endocrinology & Diabetes (MEND) **Treatment Agreement – Weight Management Program**	MRN: NAME: BIRTHDATE: CSN:

I understand the University of Michigan Weight Management Program (WMP) is a 2-year (24 months) comprehensive program designed to help me reach my weight loss goals. The program has a multidisciplinary team that includes doctors, physician assistants, dieticians and other team members who specialize in obesity and metabolic diseases. The team provides education and guidance towards making long-term lifestyle changes. I understand the WMP staff are dedicated to providing me with a personalized and organized approach to achieve improved health and my weight loss goals.

I understand the WMP has posted information about the program, which includes an overview of the program, the diet, physical activity and the costs on this website: www.med.umich.edu/weightmanagement. I am required to review this information before my first visit. I have reviewed this information either online or the information was provided to me in the mail.

I understand that to participate in the program, I must attend my scheduled clinic visits. There is a total of 37 visits. I understand to be fully enrolled in the program I must attend 80% (10 of 13 visits) in my first 6 months of visits. I understand that I must attend 80% of these visits or I will not be eligible to continue in the program. **I understand I could also be terminated from the program if I do not follow up with other physicians who may be involved in managing my other health conditions.**

Here is the WMP visit schedule:

Total number of visits	Provider	Frequency
11	Physician	First assessment visit, then weeks 3, 8, 12, 24 then every 3 months until the end of the program
26	Dietician	Weekly for 1 month, then monthly until the end of the program

I agree to talk to staff if I am having difficulty with:

- Making scheduled visits or keeping a scheduled visit.
- Following the diet, as prescribed.
- Following any recommendations, instructions and medical monitoring.

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Metabolism, Endocrinology & Diabetes (MEND) **Treatment Agreement – Weight Management Program**	MRN: NAME: BIRTHDATE: CSN:

Please read each statement and initial the lines to the left of each statement.

_____ Initials — I have reviewed the information on the website above. I understand the WMP and requirements of this program.

_____ Initials — I understand that the dietary prescription and the products that I purchase as part of the dietary prescription are intended for my personal use only and may not be distributed or sold.

_____ Initials — I understand that this program is optional (elective). Instead of the WMP I may choose an alternative program or surgery.

_____ Initials — I understand I could be terminated from the program and if I do not follow up with other physicians who may be involved in managing my other health conditions.

For female patients only

_____ Initials — I understand that if I am a female that can become pregnant (childbearing / reproductive years) I must use an effective means of contraception during the intensive dietary intervention period (usually 4 months).

Information regarding the Weight Management Program has been explained to me in detail including dietary and nutritional recommendations, physical activity requirements and medical monitoring and management of my other health conditions. They have explained the potential benefits and risks of this program. They also have explained the risks of choosing not to participate in the program. No one has made any guarantees to me about this program.

By signing this treatment agreement, I am choosing to enroll in this program and agree to participate in my care. I have read and been explained the risks and I understand them. I have had the chance to ask questions. Any questions I had were answered to my satisfaction. I have read and understand the information on this document before I signed it.

_____ **Date**: _____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship: ☐Spouse ☐Parent ☐Next-of-Kin ☐Legal Guardian ☐DPOA for Healthcare ☐Other (specify):_____

_____ _____ _____
Explained and Witnessed by Title/Credentials Provider No.

Date: _____ (mm/dd/yyyy) **Time**: _____ **A.M. / P.M.**

35-10060	VER: A/15 HIM: 05/15	Original - Medical Record Copy – Patient/Family		Treatment Agreement – Weight Management Program