Patient Responsibilities

The purpose of this document is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.

Instructions: Please read each paragraph, and once you agree to the contents of the paragraph, please write your initials on the line next to the paragraph. If you have any questions as to the meaning of any paragraph, please ask for physician to explain it to you.

_____ I understand that trust and confidence is necessary in a physician-patient relationship

_____ I understand that if I do not follow through with all of the terms of this documents that my physician may refuse to perform the procedure or may discharge me as a patient from the practice at any time.

_____ I understand that my care and treatment may include use of prescription drugs such as narcotics for pain control. I agree that if I misuse the drugs prescribed for me my physician may terminate my care and treatment. Misuse includes altering prescriptions, taking other than the prescribed dosage, or using fraudulent or illegal means to obtain drugs.

_____I will fully communicate to my physician any concerns and will also communicate to my physician or other applicable healthcare provider any suspected complications after my surgery.

_____ I agree to comply with the pre- and post-surgery protocols, which includes attending support group programs, following the diet(s) provided to me, and behavior modification.

_____ I agree to keep my follow up appointments as recommended by my surgeon and/or primary care physician.

_____ I agree to take my vitamins, calcium and other supplements for life as directed by my surgeon and/or primary care physician.

_____ I agree to have blood work done for life on an at least annual basis.

_____ I agree to see my surgeon and family physician as directed.

_____ Any medical condition that exists or may develop, not in direct relationship to the bariatric surgery, must be treated by my primary care physician (and/or appropriate specialty physician), and I agree to coordinate my care with my surgeon. I understand that my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

_____ I understand that successful long term weight loss is dependent on following the principles and guidelines of my surgeon's bariatric program.

_____ I verify that I have completed a medical history questionnaire and that to the best of my knowledge it is true and correct.

I have read this form and discussed any questions that I have with my surgeon.

Patient Name _____ (printed)

Patient Signature _____ Date _____

WITNESS:

- ☐ The Patient/Authorized Representative has read the form or had it read to him/her
- ☐ The Patient/Authorized Representative expresses understanding of the form
- ☐ The Patient/Authorized Representative has no questions

Witness Name_____ (printed)

Witness Signature _____ Date_____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign Language (specify)

_____ Sign Language

_____ Patient is blind, form read to patient

_____Other (specify) _____

Interpretation provided by _____

Fill in name of interpreter and title or relationship to patient

_____ _____

Signature (Individual providing assistance) Date