**NAME:** ______________________________ **DOB:** _____/_____/_____

**Division of Bariatric Surgery**

# WEIGHT LOSS SURGERY CONTRACT

You have decided to consider weight-loss surgery for treatment of your obesity. This surgery alone cannot make you thin and you will not necessarily lose weight just because you have a weight-loss surgery. Weight loss requires lifelong changes in your attitudes and habits related to diet and exercise. You must make a commitment to be successful.

Please initial beside each statement if you agree to the terms:

_____ I understand that this agreement is essential to the trust and confidence necessary in a provider-patient relationship.

_____ I understand that successful long-term weight loss depends on following the principles and guidelines from my surgeon.

_____ I understand that if I do not follow through with this entire agreement that my surgeon may refuse to perform the bariatric surgical procedure and/or may discharge me as a patient from the practice.

_____ I agree to follow the program as prescribed, actively participate in my aftercare and attend support group meetings as able.

_____ I agree that I will complete any testing that is required by the program or my insurance company in a timely manner.

_____ I agree that I may be financially responsible for any charges that my insurance company may not cover and agree to pay those charges which **may** include but are **not limited to: $70.00 Nutrition Consult, $35.00 Nutrition follow up appointments, Postoperative Diet, $45.00 for one month of Bariatric Postoperative Vitamins FOR LIFE.**

_____ I agree to check with my insurance company to make sure that Weight Loss Surgery is a covered benefit.

_____ I agree to follow the prescribed diets prior to and after my surgery.

_____ I agree to take Bariatric Vitamins after surgery FOR LIFE.

_____ I agree to eat only to the point of feeling full or satisfied, then stop.

_____ I agree to **AVOID** soft or melted ice cream, junk food, high calorie drinks, fried food or creamed food.

_____ I agree to keep my follow-up appointments as recommended by my provider (**OR if I am OUT OF TOWN** to maintain follow-up by phone, fax, or mail).

_____ I understand that after three (3) unsuccessful attempts to achieve program compliance that it will be recommended that I seek weight loss surgery with another institution.

_____ I understand that if I cannot document adequate weight loss during my bariatric surgery program timeline that my surgery may be cancelled.

***I have read this form and discussed any questions that I may have with my surgeon or Bariatric Program staff. By signing this contract I acknowledge that I fully understand the above and agree to adhere to all of the above for life.***

Patient Signature: ______________________________ Date: ______________________

WITNESS Signature: ______________________________ Date: ______________________

☐ The patient expresses understanding of the form and has no questions.

Bariatric Staff Signature: ______________________________ Date: ______________________

*Revised 10/12/22 JRH*