

PATIENT AGREEMENT

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Read this Agreement carefully, initial each point to indicate that you understand and agree to that point. Once you have read and understand the entire agreement, date and sign the signature page. For patients under the age of 18, the parent or guardian initials, dates and signs the agreement.

PATIENT & PROVIDER RELATIONSHIP

Initial _____ Hereafter in this Agreement, "Aftercare Provider" refers to all authorized Aftercare Providers who render Aftercare & Adjustment services for FCUSA under the terms of this Agreement. This Agreement in its entirety extends to all Aftercare and Adjustment services, received from Aftercare Provider, for the term of this Agreement.

Initial _____ As a condition of the performance of services by Aftercare Provider, I agree to provide Aftercare Provider with a complete and accurate medical history including an explanation of weight loss history, lifestyle and eating habits, any complications following my initial gastric band procedure, history of prior gastric band adjustments and other pertinent information.

Initial _____ I understand and acknowledge that depending upon my medical history and/or physical examination, Aftercare Provider may, prior to accepting me as a patient, determine that additional tests or procedures may be necessary including, but not limited to, fluoroscopy. I hereby consent to such other tests or procedures as may be deemed necessary and explained by Aftercare Provider.

Initial _____ I understand and acknowledge that , Aftercare Provider may decide he/she cannot accept me as a patient, and I agree that Aftercare Provider reserves the right to do so. Further, I understand that the initial consult fee is non-refundable, in whole or in part, under any circumstances, once the initial consult (which may or may not include an adjustment) has been conducted.

Initial _____ I understand and acknowledge that Aftercare Provider is an Independent Contractor of FCUSA in the performance of Aftercare and Adjustment services. As such, Aftercare Provider is solely responsible for my Aftercare and Adjustment services.

GASTRIC BAND

Initial _____ I understand and acknowledge that my existing gastric band is made of silicone. Further, I acknowledge that although there are no known adverse effects of having this material implanted in my body, there is no guarantee that side effects may not develop in the future.

Initial _____ I understand and acknowledge that there may be a need for surgery in the future to address possible gastric band complications. Such complications include, but are not limited to: slippage or displacement of the gastric band, or breakage or other malfunction of the gastric band device or one of its components.

Initial _____ I have been provided with written materials about the possible risks and complications which can occur during, and as a result of the adjustment procedure, as a result of the gastric band surgery itself, or as a result of my own behaviors. I understand the information presented to me.

GASTRIC BAND ADJUSTMENTS

Initial _____ I have been provided with written materials of the adjustment procedure. I acknowledge that I have reviewed and understand the information provided by Aftercare Provider regarding adjustment of my existing band.

Initial _____ A single adjustment performed by Aftercare Provider may not be the only adjustment I will need. Periodic adjustment of the gastric band will likely be required in order to achieve optimum weight loss results. Further, occasional adjustments will likely be required throughout my lifetime.

Initial _____ At any time during the term of this Agreement, Aftercare Provider may determine fluoroscopy is needed to perform an adjustment, or verify the condition and placement of my gastric band prior to Aftercare Provider performing the adjustment. Further, I will incur additional expenses if fluoroscopy is required. No refunds or other compensation will be due me, if Aftercare Provider is unable to access port, or for any other reason an adjustment cannot be completed.

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Initial_____ I understand and acknowledge that there is a possibility of damaging the port and/or tubing during adjustment. If this occurs, surgery may be required to fix the port or tubing at my expense.

Initial_____ The adjustment procedure(s) performed by Aftercare Provider, during the term of this Agreement, are being performed on a gastric band originally inserted by my former surgeon, or other healthcare provider, and not by Aftercare Provider.

Initial_____ I hereby specifically acknowledge and agree that Aftercare Provider and its agents and employees are responsible only for the specific medical care and treatment provided to me by Aftercare Provider, and not for the care or treatment that has been or will be provided to me by others. I further specifically agree that Aftercare Provider and its agents and employees shall not be responsible for any care or treatment provided by others or for complications resulting from the original placement of my gastric band or from any subsequent adjustments of my gastric band which were not performed by Aftercare Provider.

WEIGHT LOSS

Initial_____ I understand and acknowledge that it is not possible to predict the exact amount of weight I might lose, if any. Further, the amount of weight I lose depends on my own eating habits, level of physical activity, and my other weight management habits for which I accept full responsibility.

Initial_____ I understand and acknowledge that it is not possible to predict the level of difficulty I may encounter in achieving my weight loss goals. Further, there are no guarantees regarding my weight loss, and Aftercare Provider has made no guarantees about my weight loss or ultimate outcome with the gastric band.

Initial_____ Medical data shows weight loss with the gastric band can improve or cause remission of weight related medical problems, including but not limited to: hypertension, type 2 diabetes, obstructive sleep apnea and high cholesterol. I understand and acknowledge, however, there are no specific guarantees that any of these, or other obesity related conditions, will improve in any given patient, including myself.

Initial_____ I understand and acknowledge that although the majority of patients are satisfied with their weight loss, there is no guarantee that I will reach my goal weight. Further, the chances of reaching ideal body weight are very low.

PATIENT RESPONSIBILITIES

Initial_____ I understand the importance of proper nutrition, eating a balanced diet, and taking vitamin, mineral and protein supplements in order to achieve optimal weight loss and health. I agree to take responsibility for my compliance with these guidelines.

Initial_____ I understand that behavior modification is an important part of losing weight and keeping it off. I agree to take responsibility for modifying my behavior.

Initial_____ In addition to having adjustments done on my gastric band, I understand the importance of monthly follow up visits and having routine laboratory work done for weight loss and health. I agree to take responsibility for scheduling, and keeping, my appointments.

Initial_____ I am responsible for informing Aftercare Provider of any concerns, worries, or possible complications at the earliest possible time. Further, I am responsible for compliance with Aftercare Provider's instructions and/or recommendations.

Initial_____ I understand and acknowledge that weight loss is not a cure-all for psychological problems. I am responsible for seeking psychological help if necessary.

Initial_____ I acknowledge that Fill Centers USA has operating hours between 8:00 a.m. – 5:00 p.m. MST. If I should have an emergency, resulting from the adjustment of my gastric band, outside of the above specified business hours, I will need to make accommodations to seek treatment from the closest emergency room.

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PROVIDER CARE

Initial _____ Aftercare Provider shall render Aftercare and Adjustment services in accordance with generally accepted professional standards of care, safety and efficiency, and in compliance with all relevant federal, state and local laws and regulations.

Initial _____ Aftercare Provider is licensed in the state where Aftercare Provider performs Aftercare & Adjustment services. I understand and agree that any telephone consultation between me and Aftercare Provider shall be deemed to have taken place in the state where Aftercare Provider is licensed.

Initial _____ I understand that adjustments are not an exact science and there is a possibility that an adjustment may result in an overflow of my adjustable gastric band. I further acknowledge that if this should occur, I am required to notify Fill Centers USA Corporate Office within 72 hours of my adjustment, in order to receive a complimentary adjustment. In order to receive this complimentary adjustment, I will need to return back to my same aftercare provider, within one week of the original adjustment. If my aftercare provider is not available, I understand that in situations of emergencies, I should seek medical attention from the closest emergency room, to me.

TERM & TERMINATION

Initial _____ This Agreement shall go into effect upon the date Aftercare Provider accepts patient and signs Agreement. This Agreement shall then remain in effect thereafter, unless otherwise terminated in writing by either Patient or Aftercare Provider.

Initial _____ I understand and acknowledge that Aftercare Provider has the right to terminate this Agreement, if I am not compliant with medical instructions. This determination is fully the decision of Aftercare Provider.

Initial _____ I understand and acknowledge that inaccurate or false medical information may result in immediate termination of this agreement.

PATIENT SIGNATURE

I have read, or had read to me, the contents of this Agreement. I understand and agree to the terms of this Agreement.

Patient Printed Name

Signature

Date

If patient is under the age of 18, as the parent/guardian, I have read or had read to me, the contents of this Agreement. I understand and agree to the terms of this Agreement.

Parent/Guardian Printed Name

Signature

Date

AFTERCARE PROVIDER SIGNATURE

I agree to accept this patient for Aftercare and Adjustment Services.

Aftercare Provider Name & Designation/Title

Signature

Date

FILL CENTERS USA
Aftercare Provider Form