NEW DIRECTIONS

5501 Pinnacle Point Drive
Rogers, Arkansas 72758
479-268-6404

Treatment Consent Form

Authorization for Examination and Treatment

1. Having been explained the risks and benefits of the New Directions program, a medically monitored program for safe, rapid weight loss and complete education to help manage weight. I knowingly and voluntarily desire to participate in the program.

2. I am aware that I must meet medical and psychological screening criteria established by the New Directions team of weight management professionals before entering the program.

3. I hereby authorize and consent to have Program technicians perform complete physical and diagnostic procedures including blood tests, electrocardiogram ("EKG"), and possibly a stress test and/or chest radiography for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.

4. As part of the New Directions program, continuous medical monitoring is mandatory. Consequently, upon acceptance to the Program, I willingly agree to have this monitoring performed (blood tests, periodic EKG and other tests as indicated).

5. I am aware during the fasting period possible side effects may occur from ketosis. Ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). These side effects include dizziness and fruity breath. Less common, but possible side effects are fatigue, leg cramps, missed or late menstrual periods, dry skin, and temporary hair loss, sensitivity to cold, diarrhea and constipation.

6. I have been informed that foot-drop is a **RARE** transitory side effect of weight loss.

7. I have been informed that any weight loss regimen increases the chance of gallstone formation.

8. If medical complications unrelated to weight loss arise during the Program, I am fully aware I will be referred back to my private physician for treatment and evaluation.

9. I recognize that if I should become pregnant my participation in the Program must be terminated.

10. I understand that I will pay for my products and Program services on a weekly basis. I understand that it is my responsibility to pay for these services myself, but that New Directions can provide me with a letter of medical necessity (if applicable) in order for me to apply for reimbursement from or through any available insurance coverage that I may have. However, I understand that I am fully responsible for payment of the entire charges whether I have or believe I have insurance coverage that would apply.

11. The New Directions team of weight management professionals has answered my questions regarding this Program and possible side effects.

12. No guarantee has been given to me by anyone as to the results that may be obtained.

13. Having been advised of the above, I authorize and consent to the performance of the procedures and other treatment of the Program.

****FOR YOUR SAFETY, PHYSICIAN MONITORING AND UPDATING YOUR MEDICATION LISTS IS REQUIRED TO HELP MINIMIZE THE POTENTIAL FOR HEALTH RISKS****

Participant Date

**Affirmation by Physician. The matter set forth above has been explained by me to the signor of this form.

Physician Date