



Patient Agreement

- I have provided a thorough history about all medical conditions, psychiatric conditions and dietary difficulties.
- I have *reasonable* expectations of the hCG weight loss program.
- I am mentally ready to dedicate myself to this program and have support from friends and family.
- I agree to communicate with Dr. Malmgren and/or staff on generally a daily basis about my food intake, exercise, weight and any difficulties I may be having.
Phone # 303 450-9970 email: betterhealthcmd@hotmail.com
- I agree not to share, sell or trade any of the materials/information that I have been provided regarding the program, as the copywrite on the material is in force .
- I agree to adhere to all clinical recommendations, testing and follow up sessions as outlined in my treatment plan.
- I agree to use everything as prescribed and directed in the program and will not share any medication with anyone.
- I understand that the success of the program will be contingent upon my current level of health, any ongoing medical problems, and mostly, how effectively I adhere to the program recommendations.
- I understand that definite and everlasting results cannot be guaranteed.
- I understand the risks and benefits of a medical weight loss program and accept the liability of participation.
- I understand that there are no refunds for services or products.
- My signature acknowledges that I understand all the information provided and I agree to comply with the requirements as outlined above.

Patient Signature: _____

Print: _____

Witness: _____

Date: _____