

**Horizon Healthcare**  
*an Affiliate of Fairfield Memorial Hospital*  
Fairfield, Illinois

**Weight Management Program**

I desire to engage voluntarily in the Weight Management Program at Horizon Healthcare. The program will follow a plan prepared by Physician Assistant, Lois Dishman and/or my Primary Care Provider, as well as a Registered Dietician.

I am aware that Medicaid and most other insurance carriers will not cover this service. I understand I am financially responsible for the fees for this program, with payment to be made at each visit.

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Signature

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Date

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Witness

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Date