Anew
Weight Loss Center, PLLC

Consent for Treatment/Disclosure/Payment Agreement

Thank you for choosing us. Your healthcare is extremely important to us and we are honored that you have entrusted our company to assist with your medical needs. By signing this form, you are acknowledging the following:

- **Consent for Treatment:** You are giving consent to be evaluated for treatment by the health care provider(s) of Anew Weight Loss Center.

- **Disclosure**: I have been offered a copy of the HIPAA Privacy Notice and/or had it explained to me. I understand this notice and have had the chance to ask questions about any matters I don't understand.

- **Payment**: I agree, in consideration of the services being rendered to me, I am hereby individually obligated to pay my account with Anew Weight Loss Center in accordance with its regular rates and terms. If, signing as a representative, a parent or guardian, or otherwise legally responsible person for the client, I agree to the obligation described herein. All payments are expected to be fully paid prior to services being rendered. If payment is not fully paid at the time of your appointment or treatment, you will be required to reschedule until the full payment can be made.

- **Payment Options**: We accept the following payments: Credit or debit card (Visa, Mastercard, American Express, Discover), Flexible Spending Account (FSA), Health Savings Account (HSA), Apple Pay, Samsung Pay, Android Pay, and cash. We do not accept personal checks.

- **Missed Appointments**: If you are unable to keep an appointment, please notify us at least 24 hours in advance of your appointment. Failure to do so may result in a $25.00 charge to your account. All missed appointment fees must be paid prior to your next appointment booking. If you "No Show" for your appointment or cancel your appointment in less than 24 hours you may reschedule for the same day or the next business day to avoid the $25 no show fee (based on availability). New clients are required to secure their appointment with a $50 deposit. Failure to cancel your appointment within 24 hours or less will result in loss of your $50 deposit.

- **Medication Side Effects**: If you experience adverse side effects or an allergic reaction you should stop taking the medication immediately and notify our office of your reaction. If you are experiencing any chest pain, shortness of breath, throat swelling, severe nausea and vomiting, rapid heart rate, dizziness, low blood pressure, cardiac arrest, or feelings of impending doom you should call 911 immediately, as these are signs of a serious allergic life-threatening reaction. ALL clients are required to schedule a follow-up appointment for any early medication changes. No medications changes are made over the phone. You must be evaluated by the practitioner if you have experienced adverse side effects and are requesting prescription changes. The cost of the office visit will be ½ off if it has been 14 days or less since your last visit. If 15 days or more the cost of the office visit is full price.

- I have read and understand the **CONSENT FOR TREATMENT-DISCLOSURE-PAYMENT AGREEMENT** of this office and agree to abide by this policy.

Client's Name _____ Date: _____

Client's Signature _____

Updated 4/14/2020