CONSENT FOR TREATMENT/DISCLOSURE & FINANCIAL RESPONSIBILITY

Patient's name: DOB:

I hereby consent to the treatment as prescribed by my provider and provided by Dr S Weightloss & Wellness, PLLC, its employees, or representatives.

_____ initial _____ date

I have been offered a copy of the Notice of Privacy Practices and/or had it explained to me. I understand this notice and have had a chance to ask questions about any maters I don't understand.

_____ initial _____ date

I understand and agree that I am responsible for charges related to my treatment and obligated to pay my account with Dr S Weightloss & Wellness in accordance with its rates and terms. Payment in full is expected at the time of your first visit. Payment plan is available for follow up appointments.

_____ initial _____ date

Missed appointments: If you are unable to keep an appointment with our practice, please notify us at least 48 hours in advance of your appointment. Failure to do so may result in a $70.00 charge to your account. All missed appointment fees must be paid prior to your next visit. Exceptions may apply!
Payment options: We accept cash and major credit cards. We do not accept personal checks.

_____ initial _____ date

I have read and understand the consent for treatment, disclosure and payment agreement of this office and agree to abide this policy.

Patient signature _____ date:_____