OFFICE AND FINANCIAL POLICY FOR WEIGHT LOSS PROGRAM

Thank you for choosing us for your medical and weight loss needs. As one of our patients, we would like to keep you informed of the current office and financial policies for this establishment.

Please read each of the following sections carefully and initial:

Insurance: This establishment does participate with **most** insurance plans. When you schedule an appointment for the initial consultant you will be asked for your insurance information. Prior to the appointment benefits will be obtain from your insurance company. You will be advised of any financial responsibility you will have for the program according to your insurance benefits. The cost of food products will **NOT** be billed to your insurance and **must be paid for 1 week in advance.** INITIAL: ______

Payment: ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. This establishment accepts payment in the form of cash, check, Care Credit, VISA, MasterCard, American Express or Discover. **Payments made by Care Credit cannot be refunded.**
INITIAL: ______

Refund Policy: FDA laws do not permit us to restock sold items. **ALL SALES ARE FINAL.** Before a service is performed please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer. INITIAL: ____

Appointments: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We require a **24 hour notice** for canceling or rescheduling of any appointment. **There is a charge of $25.00 for each missed or late-canceled weekly appointment**. Excessive abuse of scheduled appointments may result in discharge from the program. If 2 or more consecutive weekly appointments are missed I understand that I must schedule an appointment with Dr. Corney prior to continuing the program. **I understand that after the 3rd consecutive missed appointment I will be considered as having dropped off the program.** INITIAL: ______

Appointment Times: As our patient, we value your time and want to be as transparent as possible in regards to how long you should plan on being in the office for your appointments. New Patient appointments typically take an hour to an hour and a half from check-in to check-out. Follow-up appointments usually take 15-45 minutes from check-in to check-out. There are certain times of the day when appointments are in higher demand and we are a bit busier. When scheduling your appointments, please let us know if you prefer to schedule during a less busy time of the day and we will be happy to accommodate you. INITIAL: ______

Lab Work: Lab work is mandatory for all weight loss programs. I understand that my lab work needs to be completed within the first week following my initial appointment. INITIAL: ______

Guarantee: As in any procedure, treatment or program, there is no guarantee of any particular results. Results will vary based on each individual patient. INITIAL: ______

Electronic Recording: To ensure confidentiality and privacy, the use of any type of recording device by a patient while in our office is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits. Additionally, all conversations between the medical provider and patient are documented in the patient's medical chart. To review this information, a patient may request a copy of their medical records. INITIAL: ______

Services Policy: I understand that this establishment has the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain medical services and it is at the full discretion of the medical provider to determine whether I am a candidate for any service provided. INITIAL: ______

I have read, understand and agree to the office and financial policies set forth by this establishment.

At your request, a copy of these policies can be provided for you.

PATIENT SIGNATURE ______________________________ DATE: ______________________

PATIENT'S NAME (PLEASE PRINT)