Women First
MARGIE CORNEY, MD
OB/GYN & ASSOCIATES

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 weekly** INITIAL: ______

Payment: ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE; however, some services may require a deposit in advance. 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: ______

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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) ____

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Cancellation Policy

I understand that I am responsible for a **$25.00** fee if a **24 hour** notice to reschedule or cancel my appointment is not given. These fees also apply to **each missed** weekly appointments.

I understand that I will be billed for this fee and payment is due before I can reschedule my next appointment.

PATIENT SIGNATURE ______________________________________ DATE: ___________________________

PATIENT'S NAME (PLEASE PRINT) ____

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Notice of Privacy Practices

In accordance with HIPAA federal regulations, this establishment will not disclose any information about you or your personal health, without your permission. All information received while a patient (and if/when you decline to be a patient no longer) will be kept confidential.

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, you consent to the use and disclosure of your protected health information by our staff, and our business associated ***strictly for the purpose of treatment, payment and health care operations.***

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. It provides more detail on how we may use and disclose of your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, by contacting our office manager.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information ***for the purposes of treatment, payment and health care operations.***

PATIENT SIGNATURE ______________________________________ DATE: ___________________________

PATIENT'S NAME (PLEASE PRINT) ____

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PROGRAM COST

This establishment does participate with **most** insurance plans. The cost of food products will **NOT** be billed to your insurance and **must be paid for weekly.**

We strive to make weight loss affordable. We offer a combined insurance/self-pay model for our Medical Weight Loss Program. We bill your insurance for covered benefits whenever possible in order to lessen out of pocket costs and reduce self-pay patient responsibilities. For **Self-Pay Patients,** those without insurance or whose insurance benefits does not cover preventive counseling for obesity or weight reduction, we have self-pay rates available for all products and services. We offer **weekly or bi weekly** payment plans. **Food products may not be included in the payment plan and must be paid for 2 weeks in advance. Final payment must be made prior to or at the 15th weekly office visit.**

To help you understand our pricing model, here are some examples of potential covered and non-covered benefits.

For insured patients, covered benefits could include:

- Weekly office visits with co pay
- Physician office visits with co pay
- Lab work

Self-pay or out-of-pocket expenses (for Insured and Non-insured Patients) include:

- Food and beverage
- Electrocardiogram test
- Multivitamins and Supplements

Rates for self-pay patients for services and products are as listed:

- **Program Cost $875.00**

The program cost includes:

- Your initial comprehensive health assessment with a doctor
- Weekly behavior modification sessions for 16 weeks
- Medical supervision by a doctor
- 1 set of Lab work
- Periodic electrocardiogram tests as warranted
- **Food Products**
  - 800 calories diet $60.00 weekly
  - 1000-1500 calories diet $48.00 weekly

Payment Plans

- **Weekly**
  - 16 weekly payments
  - 8 bi weekly food cost payments
- **Bi-weekly**
  - 8 bi weekly payments
  - 8 bi weekly food cost payments