## Divine Weight Management Office and Financial Policies

**We would like to thank you for choosing divine healthcare for your weight loss needs. As one of our patients, would like to keep you informed of the current office and financial policies for this establishment.**

**◆There is a minimum of 12 contractual weeks in the weight lost program. If there are more than 3 missed or rescheduled appointments, Patient may be discharged or have to restart program with applied new patient fees.**

**Please read each of the following sections carefully an initial:**

**Insurance:**

**Divine Healthcare does not participate with any insurance companies for the weight lost program. We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnostic codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance company.**

**Initial:_____**

**Payments:**

**All payment Is Expected At The Time Of Service, however, some services may require a deposit in advance. This establishment accepts payments in the form of Cash, VISA, Master card, Discover, and American Express. We do not accept checks.**

**Initial: _____**

**Refund policy:**

**DHC will provide patients with prescription medication and are subject to state and federal laws. These laws do not permit us to restock sold items or accept return prescription medications for refund. 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 service we offer.**

**Initial: _____**

**Appointments:**

**Broken appointment 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 counseling or rescheduling of an appointment. There is a charge of $25.00 to a $150.00 per hour for missed or late – canceled appointments. Excessive abuse of scheduled appointment may result in discharge from the practice.**

**Initial: _____**

**Appointment Times:**

**As our patient, we value your time you 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 30 minutes to 45 minutes from check and to check out.**

**Initial: _____**

**Prescription medication:**

**Many of the medications that are prescribed by the medical providers here at Divine healthcare are deemed as controlled substances and must be monitored regularly. All patients are required to have an appointment with a medical provider in order to receive any prescription refills. The control medication will be dispensed in office at the time of your visit. If you choose, we will provide you with the present written prescription to have filled at Cornerstone Rx, however a program fee will still apply.**

**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. I also understand that if the results are not received by DHC prior to my second appointment, I will not be prescribed any additional medications.**

**Initial: _____**

**Guarantee:**

**As in any 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 patient while in any of our offices 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 the patient are documented in the patient's medical record. 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 the 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 provider.**

**Initial:_____**

**I have read, understand and agree to the office and financial policies – forth by DHC. I understand that my initials and signature is legally binding.**

**Patient Signature:_____ Date: _____**

**Patient's Name(Please print): _____**

## Cancellation Policy:

**I understand that I am responsible for the following fees, if a 24-hour notice to reschedule or cancel my appointment is not given. These fees also apply to missed appointments.**

| | |
|---|---|
| **Weight Loss Appointments:** | **$25.00** |
| **Medical Follow up Appointments:** | **$25.00** |
| **Accident Appointments:** | **$25.00** |
| **New Patient Appointments:** | **$50.00** |

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

**Patient's Signature:** _____

**Date:** _____

**Patient's Name ( Please print):** _____

## CONSENT – WEIGHT LOSS CONSULT

**I authorize Divine Healthcare, LLC, to assist me in my weight loss reduction efforts.**

**Potential Risks:**

- ✓Allergic reactions to prescribe medication and supplement
- ✓Side Effects of Medication
- ✓Inconvenience of lifestyle changes

**I understand that some medications and supplements may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain existing disease conditions.**

**I do not expect my medical provider to be able to anticipate and explain all risks and potential complications. I wish to rely on the judgment of the medical providers in recommending programs that they feel are in my best interest, based on the available knowledge.**

**I have the opportunity to ask questions and discuss with the medical staff to my satisfaction:**

- My condition
- The nature, purpose, and potential benefit of the proposed medical
- weight loss program
- The potential risks associated with the medical weight loss program
- The probability of those risks occurring
- The likelihood of success
- The possible consequences if advice is not follow and/or no weight
- loss program our undertaking

**Acknowledgment of Laboratory Procedures:**

**I understand that DHC had a contracted account with a specific laboratory. This contract is only for specific blood loss. It is against the law for the patient to add any additional tests to a lab order. I understand that if I add any additional blood test to a lab order, or request the laboratory to add additional blood tests under this order, I am responsible for all charges in addition to the cost of the initial visit fee.**

**I understand that I am permitted to have my blood drawn at any designated laboratory location with and approved lab order slip from my Primary Care Provider.**

**I understand that this weight loss program does not replace the services of my primary care physician or specialists (cardiologists, oncologist, gastroenterologists, OB/GYN.)**

**Injection Consent:**

**I understand that my medical provider may prescribe a vitamin shop and/or fat burning shot that must be given by intramuscular (IM) injection. IM injections use a needle and syringe to deliver medication two large muscles in my body. They are usually given in the buttocks, thigh, hip, or upper arm. Treatments are typically well tolerated with no serious adverse reactions.**

**Potential Side Effects:**

- **Injection site reaction - temporary redness, pain or tenderness, an**
- **irritation of the skin surrounding the injection site.**
- **Bruising - this response is temporary in may occur at the side of the injection.**
- **Infection - Very rare complication but possible anytime in injection to the skin is performed.**

**I have fully read and understand this consent form, and I realize that I should not sign this form if I have any questions concerning these injections. I understand the potential side effects, benefit and give my consent to receive these injections.**

**Initial:** _____

**FEMALE PATIENTS ONLY: I certify that I am not pregnant at this time, and if I do become pregnant I will immediately stop the weight loss program along with any weight loss medication, and notify this office immediately.**

**Initial:** _____

**Patient Signature:** _____ **Date:** _____

**Patient's Name: (Please Print):** _____