INTEGRATED MEDICAL WEIGHT LOSS

Your permanent weight loss is our passion

Patient Name _____

24 Hour Cancellation Policy Acknowledgement

As a courtesy, and to help patients remember their scheduled appointments, IMWL provides **two** (phone call/text/email) reminders for each appointment (1 week and 2 days in advance).

If you are unable to keep your appointment, we do require 24-hour notice. Please contact us so we can reschedule your appointment and accommodate those patients who are waiting to see our providers.

If you do not cancel or reschedule with at least 24 hours' notice, we will assess a **$75.00** "no-show" service charge to your account. This no-show charge is not reimbursable by your insurance company.

Thank you for your understanding and cooperation with this policy.

_____ _____

Signature of Patient or Responsible Party Date

Credit Card Information & Authorization

I hereby authorize Integrated Medical Weight Loss / Yestermorrow, PC to charge the credit/debit card listed below for the following charges (please check all):

☐ **Copays** ☐ **Deductible** ☐ **Missed Appointment Fee (as outlined above)**

I guarantee and warrant that I am the legal cardholder for this credit/debit card and that I am legally authorized to enter into this one-time or billing agreement. I understand that this office will not charge my credit card for anything other than the reason set forth in this agreement.

☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Holder name (as shown on card): _____

Billing Address: _____

Street City State Zipcode

Credit Card #: _____ Expiration Date: _____

_____ _____

Signature of Card Holder (Required) Date

Updated 10/27/2020

INTEGRATED MEDICAL WEIGHT LOSS
Your permanent weight loss is our passion

Patient: _____

1. Financial Policy

We are happy you have chosen Integrated Medical Weight Loss for your healthcare and weight loss needs, and are looking forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. We suggest you contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we participate with, payment in full is expected at each visit. As a convenience, we offer discounted rates for self-pay patients.

Co-Payments and Deductibles: All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Thank you for understanding our payment policy. Please contact us if you have any questions or concerns.

~ I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of Patient or Responsible Party Date

---

2. Acknowledgement of Privacy Practice (HIPAA)

By signing below, I am consenting to allow Integrated Medical Weight Loss to use and disclose my PHI to carry out treatment, payment and healthcare operations. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read. I understand the Notice of Privacy Practices and agree to its terms.

_____ _____
Signature of Patient or Responsible Party Date

---

3. PHI Disclosure Designation

I agree that Integrated Medical Weight Loss may disclose certain areas of my health information to a personal representative noted below, since such person is involved with my healthcare or financial responsibility related to my healthcare.

_____ _____
Name of Contact Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date