Medi-Slim
Weight Loss & Spa

Medi-Slim Weight Loss
Patient Information Form

Patient Name (Last): ..... (First): ..... (MI): .....

Name you prefer to be called: .....

Patient Address: .....

City: ..... State ..... Zip .....

Phone number you would prefer us to use: .....

May we email you? ☐ **Yes** ☐ **No**

If yes, email address: .....

Birthdate: ..... Age: ..... Sex: ☐ M ☐ F

Employment Information:

Patient Employer: ..... Occupation: .....

Driver's License Number: ..... State: .....

In Case of Emergency:

Name: ..... Relationship: ..... Phone: .....

Family Physician: ..... Phone: .....

How did you hear about us?

☐ Direct Mail ☐ Radio ☐ Drive-by TV ☐ Brochure ☐ Internet ☐ Yellow Pages ☐ Friend

If referred, by whom: .....

We appreciate referrals. When you refer another patient, you will receive $15 off your next visit!

Financial Policy:

Thank you for selecting Medi-Slim Weight Loss and Dr. Pamela Gabriel for your weight management needs. We are honored to be of service to you, your family and friends. This is to inform you of our financial policy.

Please read and initial the items below.

..... Payment for all services will be due at the time services are rendered. There will be no exceptions.
For your convenience, we accept all major credit cards, Debit Cards, checks and cash.
..... Payment for packages must be completed before treatment has begun.
..... Package treatments must be completed within 6 months of the date of purchase or they will expire.
..... Packages cannot be transferred to another patient or changed to another service.
..... We do not offer refunds.
..... We cannot accept returns of any food items.
..... If a patient is to return after being absent for 12 months, the full new patient price will be applicable.

I have read and understand all of the above and have agreed to these statements.

....
Physician Signature *Date*