AIM WELLNESS

Co-Pay:_____

Date: _____

Weight Loss New Patient Information

Name:_____DOB:_____
(First) (Middle) (Last)

Address:_____City:_____Zip:_____

Sex: Female or Male
SSN:_____
Marital Status:_____

Phone: Home: _____Cell: _____Work:_____

EMAIL:_____

Employer:_____
Occupation:_____

Have you see Dr. Jeannine Parikh Before?_____
Referred By_____

Emergency Contact
Name:_____Relationship:_____

Phone: Home_____Cell:_____Work:_____

Street Address:_____City:_____State:_____Zip:_____

Primary Insurance:
Policyholder Relation: Self:_____Spouse:_____Parent:_____
Name of Policyholder:_____DOB:_____SSN:_____

Secondary Insurance:
Policyholder Relation: Self:_____Spouse:_____Parent:_____
Name of
Policyholder:_____DOB:_____SSN:_____

WEIGHT CONTROL EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How much weight do you expect to lose? _____Each week?_____Each Month?_____

What size clothes do you expect to be able to wear when you reach your goal weight? _____

What do you expect from us (your medical counselors)? Be specific:

_____

Will it change your life in any way (for better or worse) when you reach your goal weight?_____

Do you expect to be doing anything you are not doing now? (describe in detail)_____

_____

Do you expect to STOP doing something you ARE DOING NOW? (describe in detail)

_____

_____

How will family and friends respond to the “new you?”_____

Will you get more respect from other people?(Who specially)_____

Will you feel comfortable with these altered responses from others?_____

Will you be more sociable than you are now?_____

What will happen if some of your expectations don’t come true? What might you do?_____

_____

What do you expect to have to do to maintain weight the same?_____

_____

Will you continue to watch your food intake?_____Exercise?_____

Continue with professional medical monitoring?_____
For about how long?_____

Do you have any other expectations than those listed above?_____Specifically, what are they? Please describe them in detail. _____

Brief Medical History

1.) List all prescription and over-the-counter medications, Vitamins and Supplements you are taking:

Name Dosage Physician (if prescribed)

_____

_____

_____

_____

_____

_____

_____

_____

2.) Did you exercise? Yes or No If Yes, how many days:_____ Total # Minutes:_____

3.) Have you had any chest pain, shortness of breath or heart palpitations with physical activity? Yes or No

4.) Do you drink at least 32 ounces of water daily? Yes or No

5.) Have you experienced any of the following while dieting: (please circle)

Hunger Vomiting Nausea Indigestion Constipation Irritable, Anger Fluid Retention Diarrhea Cravings Numbness Cold Extremities Lack of Control Leg Aches Chest Pain Tremors Dizziness Shortness of Breath Confused Light Headed Fainting Feeling Weak Headaches Rapid Heart Beat Cramps, Gas Lack of Interest Moody Feeling Spacey Depression Difficulty Sleeping Rashes

Other:_____

9.) Have you been diagnosed with any of the following?

Heart disease Kidney disease Stroke Depression Obesity

Seizure disorder Thyroid problem Arthritis Liver disease Anemia

High Blood Pressure Glaucoma Diabetes Lung problem Cancer

High Cholesterol Ulcers Bone/joint problem

Other: _____

10) Please list history of any Surgery including weight loss surgery: If weight loss please include when response, amount of weight lost and any regained: _____

_____

_____

10.) Drug allergies:_____

12.) For Females Only: LMP:_____Birth Control:_____

Are you pregnant: Yes No Maybe Not Sure

13.) What is the most you have ever weighed?_____

14.) What is your Goal Weight? _____

NOTICE OF PRIVACY PRACTICES

(SHORT FORM SUMMARY)

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations: We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI: We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

Contact Us

Please inquire with any staff member should you have any questions, comments, or complaints; or to exercise any of your rights at Ashland Integrative Medicine.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of AIM's Notice of Privacy Practices effective 09/23/2013.

PRINTED Name of Patient **SIGNATURE of Patient or Responsible Party** **Date**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Insurance does not pay for Body Composition Analysis or if your BMI is under 30; therefore, you may have to pay. Insurance companies do not pay for everything, even some care that you or your healthcare provider have good reason to think you need.

Service	Reason Insurance May Not Pay:	Estimated Cost
Body Composition Analysis	Our device is non covered by Health Insurance Companies	$25 each visit
Office Visit	If BMI is under 30	$75.00 each visit
Meal Replacements	Insurance companies do not cover food	$3.00 per item
Vitamin Injections	No medical indication without deficiency	$12-$20 per injection

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

This notice gives our opinion, not an official Insurance decision. If you have other questions you may call the number on the back of your card.

Please be aware that some, and perhaps all, of the services provided may be non-covered services that are not considered reasonable and necessary by your insurance carrier.

Participating Insurance Plans

For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

Non Participating Insurance Plans

For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment by cash or charge (Discover, Visa, Mastercard, American Express) are expected at the time of service. Your policy is a contract between you and your insurance company,

Minors

A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Authorization to pay benefits to physician/office

I hereby assign payment directly to AIM Wellness for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance, this includes charges that apply to co-insurance and/or deductible.

Authorization to release information

I hereby authorize AIM Wellness to release any information acquired in the course of my examination or treatment to my referring physician and/or my insurance company.

Acknowledgement

I have read and understand the above Financial Policy and Benefit Authorization and agree to all provisions outlined herein.

NAME: _____
SIGNATURE :_____
DATE: _____

Nutritional Product Payment Agreement

Payment is necessary for all nutritional products in full prior to services being rendered for the medical weight loss program. The payment is non-refundable and non-transferable. Food is non-exchangeable due to Department of Health Regulations.

By signing below, you acknowledge that you have received this notices and understand the above policies

_____

Patient Signature **Date**

Informed Consent for a Low Calorie Diet

We want you to know…
When you decided to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight.

The calorie deficit and portion-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974.

Your role…
Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem, eating, activity and lifestyle patterns so your health care professional can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phases.
- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your appointments regularly if appropriate, and following your diet and exercise prescription.
- Allow your health care professional to share information with your personal physician.
- Make and keep follow-up appointments with your physician and have any blood test taken or any other diagnostic measure made which your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by your health care professional and your physician.

- It is vitally important for you to advise the clinic staff on ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the center informed of any questions or symptoms you have, affords the best chance of intervening before a problem becomes serious.

Potential benefits…
Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:

- Lower blood pressure, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see our physician as needed to have your need for these medications reassessed. Our health care professional will share your results with your physician on a regular basis so the physician is informed about your progress.

Other benefits may also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits, as well.

Possible side effects…
The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary. In addition it is conceivable other side effects could occur that have not been observed to date.

Reduced Weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. In addition, your body makes some other adjustments in physiology. Some of these are responsible, in some participants, for rapid improvements in blood pressure and blood sugar; other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, a slower heart rate , dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

Reduced Potassium Levels. The calorie level you will be consuming is 800 or more calories per day, and it is important that you consume the calories that have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

Gallstones. Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstone (pain, diagnosed stoned and/or surgery) in individuals 30 percent or more over desirable body weight (50 pounds or more overweight) not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 0-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals entering a weight loss program showed that as many as 1 in 10 had “silent” gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight—especially rapidly—may increase the chances of developing stones or sludge and/or increasing the size of existing stones within the gallbladder. Should any symptoms develop (the most common are fever, nausea and a cramping pain in the right upper abdomen or if you know or suspect that you may already have gallstones), let your physician and health care professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. A drug (Actigall) is currently available that may help prevent gallstone formation during rapid weight loss. You may wish to discuss Actigall with your primary care or weight management physician for more information.

Pancreatitis. Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the right upper

abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long- term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your health care professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

Binge Eating Disorders. Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one study to increase binge eating episodes temporarily. Several other studies demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The risk of weight regain…
Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs.

Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets (including modified fasting) have shown varying results for the percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program.

Sudden Death. Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded of some tiredness, psychological problems, medication allergies, high blood pressure, rapid heart rate and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Your rights and confidentiality…
You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure the physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

By signing this informed Consent, you state: I understand the information about my treatment in the weight management program offered by the center identified below is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others. I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

Resale of Products…
Any products purchased through this weight management program, including Multivitamins, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any of the products purchased through this weight management program.

I, the undersigned, have reviewed this information with my health care professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.

Patient Signature:_____Date:_____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have answered any questions posed by the patient. I believe the patient/relative/guardian fully understands what I have explained and answered.

PROVIDER SIGNATURE:_____

Date:_____

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:
1. I, _____ (patient or patient's guardian) authorize Dr. Jeannine Parikh and Allison Pennington, ARNP to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.
2. I have read and understand my doctor's statements that follow:
"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The

appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling. As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below). As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants used in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

6. I understand that it is my responsibility to take precautions not to become pregnant while on medication. I will inform my healthcare provider if there is a chance that I may be pregnant, and I will refrain from taking medication until such time as I know for sure that I am not pregnant.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED

TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE DOCTOR or NURSE PRACTITIONER NOW BEFORE SIGNING THIS CONSENT FORM.

Patient Signature **Date**

VI. HEALTH CARE PROVIDERS DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Jeannine Parikh, MD/ Allison Pennington, ARNP

Consent for Lipo B/C and B12 Injection

We have available to anyone who wants or needs Lipo B and B12 injections. Lipotropic Enzymes + B12 (Methylcobalamin) A Lipotropic substance decreases the deposit, or speeds up the removal of fat (Lipo = fat, tropic = stimulate) within the liver. Lipotropic nutrients are a class of agents that play important roles in the body's use of fat. These compounds enhance the liver and gallbladder's role by decreasing fat deposits and speeding up metabolism of fat and its removal. Your liver is the organ responsible for removing fat and toxins from your body, so if it is healthier, it will work better for you. The key amino acids used to make these shots are: Choline, Methione, and Inositol. Vitamin B12 is essential for helping to form new, healthy cells in the body. It also boosts energy, helping to increase activity levels. Our Lipo-B injection combines lipotropic agents with a highly absorbable form of Vitamin B12 called Methylcobalamin.

Methlycobalamin is the specific form of B12 needed for nervous system health.

Choline supports the health of the liver in its processing and excretion of chemical waste products within the body. Moreover, it is required for the transport and metabolism of fats and cholesterol within the body, which is important for the healthy support of the endocrine, cardiovascular and hepatic systems.

Methione is one of the sulfur-containing amino acids (cysteine & cystine are others) and is important for many bodily functions. It acts as a lipotropic agent to prevent excess fat buildup in the liver and the body, is helpful in relieving or preventing fatigue and may be useful in some cases of allergy because it reduces histamine release. Patients with a Sulfa allergy should not take this injection.

Inositol, a nutrient belonging to the B vitamin complex, is closely associated with Choline. It aids in the metabolism of fats and helps reduce blood cholesterol. Inositol participates in action of serotonin, a neurotransmitter known to control mood and appetite. The different ingredients of this mixture are known to have the following attributes: Proper metabolism of fats and removal of fat from the liver. Energy boost. Speed up the thought process and improve mood. Building blocks for cell

walls. Essential components for normal cell and brain function. Help control cholesterol levels and gallstones. Helps emulsify cholesterol and detoxify amines. Helps keep healthy skin tone and strong nails. Promote healthy hair growth, and controlling estrogen levels. Help with transforming carbohydrates into energy. Aiding in digestion.

Patient Signature **Date**

Financial Policy

Welcome and Thank you for choosing AIM Wellness as your healthcare provider. We are committed to delivering the highest quality of care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be non-covered services that are not considered reasonable and necessary by your insurance carrier.

Participating Insurance Plans
For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file upon each visit. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

Non Participating Insurance Plans
For those plans with which we do not participate - we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment(s) by cash or credit card/debit card are expected at the time of service. Your policy is a contract between you and your insurance company.

Minors
A minor must be accompanied by a guarantor for his/her account - with said parent/guardian of the minor or other adult accompanying the minor during each visit. An unaccompanied minor will always be denied non-emergency treatment unless charges have been pre-authorized to an approved credit/insurance plan.

Authorization to pay Benefits to Physician/Office
I hereby assign payment directly to AIM Wellness for medical and/or surgical benefits - if any - otherwise payable to me for services provided at the clinic...not to exceed my indebtedness to the clinic for those services. I understand that I am financially responsible for any charges for provided services not covered by my insurance, this includes charges that apply to co-insurance and/or deductible - said charges are due at the time of service.

Authorization to Release Information
I hereby authorize AIM Wellness to release any information acquired in the course of my examination or treatment to my referring physician and/or my insurance company.

Account Balances
We will require that patients with outstanding balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the Office Manager with whom they can review their

account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Acknowledgement
I have read and understand the above Financial Policy and Benefit Authorization and agree to adhere to all provisions outlined herein.

_____

Patient Signature **Date**

Cancellation Fee Policy

AIM Wellness is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. With that said - we understand that there are times when you must miss a scheduled appointment due to emergencies and/or obligations for work or family. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment schedule.

Therefore, if you need to cancel and/or reschedule an appointment you are required to call no later than 24 hours prior to the scheduled appointment time. If you need to cancel/reschedule a Monday appointment - you must call prior to close of business on the Friday prior.

If an appointment is not canceled at least 24 hours in advance of your scheduled appointment time you will be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company and must be paid prior to your next appointment. Multiple Non-Cancellation/No-Show events in any given 6 month period may result in termination from our practice.

_____

Patient Signature **Date**

Late Arrival Policy

AIM Wellness understands that delays can happen - however, we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes or more past their scheduled appointment time we will have to reschedule the appointment.

_____

Patient Signature **Date**