Eze Wellness & Weight Loss for Teens - Program & Contract

(Revised February 2018)

Teen Weight Management **Monthly Plan- $130 / month (4 visit package)**

This program concentrates on weight loss goals to healthily reduce excess weight while learning and adapting to the new lifestyles and habit changes necessary to maintain it. It is designed specifically for patient ages 14- 17.

Plan Includes:

Weight Loss Jumpstart (1 week)
Medical & Nutritional Evaluation (1st visit)
Body Composition Analysis (each visit)
Referral for Comprehensive Bloodwork (done at outside lab)
Review of bloodwork results (2nd or 3rd visit)
Energy-boosting B-12 shots (each visit) * optional *
Weight Loss supplement guidance
Nutrition and Exercise Counseling
Behavior Modifications Counseling
Weight loss monitoring & plan modifications (weekly)

**** Purchase of the Eze Wellness & Weight Loss Vitamin Packs is required. Cost = $40 / month supply****

~ Recommended 3 month or more program continuation for weight loss goal of 20 lbs or more ~

****PARENT/ GUARDIAN REQUIRED TO ATTEND EACH PATIENT VISIT ****

Acceptance of the above mentioned program assumes that the patient has been cleared and approved by the primary doctor / pediatrician prior to the start of the program.

PATIENT ACKNOWLEDGEMENT/CONSENT FORM - Use & Disclosure of Protected Health Information
We are required by applicable federal and state laws to maintain the privacy of your health information according to HIPPA regulations.

ADHEARENCE TO WEIGHT LOSS PROGRAM
I understand that while on the Eze Wellness and Weight Loss Program, it is my responsibility to adhere to the recommendations given in order to achieve my weight loss goals. I acknowledge all potential risks of starting a Medical Weight Loss program and I have been cleared by my physician prior to beginning it.

PHOTOGRAPHY CONSENT FOR TREATMENT ASSESSMENT
I authorize Eze Health Center medical personnel to take photographs of me and to use them as an aid in assessment of my weight loss progress. I understand that these photographs will help document the progress of my treatment, and that any photographs taken will remain the property of the facility. I also understand that these photographs will not be utilized for any other purposes without my consent.

SERVICE & PAYMENT POLICY
I understand that FULL payment for all programs will be due at the time of service and that this payment is non-refundable. I also understand that program costs are according to established fees at the time contract is signed and that there will be no submission of fees to a Health insurance company.

By signing , I (Patient Name) ____agree to the terms of this contract as stated above.

Patient Signature ____ Date: ___________________

Parent/ Guardian Name ____