MD Weight Loss
3711 Garth Rd. Suite 160 Baytown, TX 77521
Office: 281.201.8243 Fax: 281.836.4708
www.mdweightlosscenter.com

Patient Information Form

Patient Name: (Last)______________________________(First)________________________(MI)________

Birthdate: _______________________________________Age: _________ Sex: M F

Patient Address: ____

City: ____ State: ______________ Zip: ________________

Home Phone: _____________________________________ Cellular: ________________________________

Email Address: ___________________________________ Driver's License: _________________________

Occupation: ______________________________________ Employer: _______________________________

Emergency Contact:

Name: ____________________________Relationship: _______________ Phone: ____________________

Patient's Spouse: ____ Phone: ____________________

Family Physician: ____ Phone: ____________________

Referred by: [ ] Newspaper [ ] Internet [ ] Family/Friends [ ] Other___________________

Financial Policy:

Please be advised that **we do not participate with Medicare, Medicaid, or any other government sub-sidized insurance plans**. If you have Medicare coverage, then you will be charged the limiting fee; we will submit your claim to Medicare so that you can be reimbursed. If your insurance plan does not cover our services, then special financing and pricing is available. Verification of coverage will be done before services can be rendered. For your convenience, we accept Visa, MasterCard, Discover, cash and checks. If a check is used, the check must be in the patient's name or check signer must be present with a valid I.D. A $50 fee will be charged for any returned check.

Patient Statement:

I understand that payment for all services will be due at the time services are rendered, unless prior ar-rangements have been made. All treatments and treatment packages are non-refundable and non-transferrable.

If I fail to contact MD Weight Loss to cancel a future scheduled appointment and I do not show, I agree to pay a $20 fee billed on the day of the missed appointment. **Please be advised that if you are more than 15 minutes late to your scheduled appointment, you will be asked to reschedule.**

I agree that should this account be referred to an agency or an attorney for collection, I will be responsi-ble for all collection costs, attorney's fees and court costs.

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

_______________________________________ _______________________________________
Patient's Signature Date