General Consent:

Communication:
Heartland Weight Loss periodically corresponds with patients using SMS, phone, and/or email. SMS and email are not secure, so personal health information will not be discussed on these platforms, however, they may be used to communicate information regarding scheduling, special events, and any other non-medical correspondence.

Initial:__________

Confidentiality:
Patient information may be used to collect statistics to compare results and improve the treatment of obesity. This de-identified information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

Initial:__________

Sharing of Information:
Many of our patients allow family members to call and discuss schedule changes, medical information, and/or financial information. We are not allowed to give this information to anyone without your consent. If you would like to permit someone else to speak with us regarding any/all of these matters, you must provide their full name, relation to you, and what information you permit us to discuss with them. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Heartland Weight Loss to release my records and any information requested to the following individuals.

__________________________ **Relation:** _______________ O scheduling O medical O financial

__________________________ **Relation:** _______________ O scheduling O medical O financial

Scheduling:
A $50 deposit is required to hold all new patient appointments and will be applied to charges incurred. The deposit will be forfeited if the appointment is canceled or rescheduled less than 48 hours before the scheduled time or if the appointment is missed altogether.

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 48 hours before your scheduled appointment time. If you do not show up for your appointment, cancel, or reschedule within 48 hours of your appointment time, you will incur a $50 fee. If this fee is not paid when the appointment is canceled/missed, it will be added to the next month’s automatic charge.

Initial:__________

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Billing:

Patients are required to keep a credit card on file and monthly packages will be processed automatically on the same day each month. Services purchased as part of a package must be redeemed within 30 days and cannot be carried over to subsequent months. If an automatic payment is canceled or declined, any upcoming appointments will be canceled. If you choose to cancel your recurring charge, you must notify us in writing (by email or via the patient portal) at least 48 hours before the charge is scheduled to be processed. Refunds will not be given.

Initial:__________

Health Insurance Portability and Accountability Act (HIPAA):

I have been given a chance to review the HIPAA policy. All questions I have concerning this policy have been answered to my complete satisfaction.

O I decline to receive a paper copy of the HIPAA policy

O I would like to receive a paper copy of the HIPAA policy

Initial:__________

I have read each of the sections above. My initials following each section indicate my understanding of the information and I agree to comply with the policies.

Signature: ____ Date: ______________

Printed Name: ____

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