Informed Consent for Treatment of a Minor:

We cannot legally treat a minor child without a signed consent form. You must be present at your child's initial visit to sign the parental consent form

Minor Information:

Patient Name:_____ Patient DOB: _____

Parent/Legal Guardian Information:

Name: _____ SSN#: _____

DOB: _____ Primary phone #: _____

Relationship to Patient: _____ Secondary phone #: _____

If you are not the parent, you will need to provide legal documentation that you are the legal guardian. The information will be kept in the patient's file.

Special Permissions: this agreement is required for the minor child to be treated in person or via a secure telehealth platform without the parent/legal guardian present.

_____ (initials) **Unaccompanied:** I grant permission to treat and provide any healthcare services to the minor child that the provider deems necessary for treatment if my child arrives at the office or engages in a telehealth visit unaccompanied

_____ (initials) **Accompanied by others:** If I am unable to accompany the minor child to the appointment or be present during a telehealth visit, the below-listed individual(s) have my permission to accompany my child or be present with them on a telehealth visit and make medical decisions regarding the child:

Other individuals Allowed to Accompany Minor:

Name: _____ DOB: _____ Relationship to Child: _____

Name: _____ DOB: _____ Relationship to Child: _____

Consent to treat Minor: I authorize Heartland Weight Loss to treat and provide any healthcare services to my child deemed necessary for treatment and/or diagnosis. I acknowledge that this consent will remain in effect until I revoke it in writing and present this document or the minor reaches the age of 18 years.

By signing below, I certify that I have read the above information and have had any questions answered. MY signature also certified my understanding and agreement with the above information:

Parent/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

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

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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:_____

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: _____