ADVANCED MEDICAL WEIGHT LOSS

4460 S. HIGHLAND DR. # 400
SALT LAKE CITY UT, 84124
(801) 272-4111

DATE __________________

PATIENT NAME____
FIRST M.I LAST

PATIENT ADDRESS ____
STREET ADDRESS (NO PO BOXES)

____
CITY STATE ZIP

HOME PHONE # (______) ___________________ BIRTH DATE ___/___/____ GENDER (circle one) M F

SOCIAL SECURITY # ________/_______/_______ MARITAL STATUS S M W D

DRIVER'S LICENSE # _______________________ STATE _______________________

EMPLOYER _______________________ WORK PHONE # (_____) _______________________

WORK ADDRESS ____
STREET ADDRESS

____
CITY STATE ZIP

PERSON RESPONSIBLE FOR PAYMENT ____
☐ SAME AS ABOVE FIRST M.I. LAST

MAILING ADDRESS ____
STREET ADDRESS (NO PO BOXES)

____
CITY STATE ZIP

HOME PHONE # (______)____________________ WORK PHONE # (____)_________________________

SOCIAL SECURITY # _______/______/_________ DATE OF BIRTH ______/________/________________

RELATIONSHIP TO PATIENT____

EMERGENCY CONTACT # 1_________________ PLEASE LIST ALL MEDICATION ALLERGIES:

PHONE # (______) _________________________ _________________________

EMERGENCY CONTACT # 2_________________ _________________________

PHONE # (______) _________________________ PHARMACY_________________________

PHARMACY PHONE # _________________________

WHO MAY WE THANK FOR REFERRING YOU TO US? _________________________

<OVER>

CONDITIONAL AGREEMENT

RELEASE OF INFORMATION: THE UNDERSIGNED AUTHORIZE THE OFFICE OF ADVANCED MEDICAL WEIGHT LOSS TO RELEASE PART OR ALL OF THE PATIENT'S RECORDS TO ANY PERSON OR ORGANIZATION LIABLE FOR THE BILL (CHARGES).

FINANCIAL AGREEMENT: PAYMENT FOR SERVICES PROVIDED BY ADVANCED MEDICAL WEIGHT LOSS IS PAYABLE BY CASH, MAJOR CREDIT CARD OR APPROVED CREDIT ONLY. WE DO NOT BILL YOUR INSURANCE OR ACCEPT PAYMENT FROM YOUR INSURANCE, EVEN IF YOUR INSURANCE COVERS THE SERVICES PROVIDED BY ADVANCED MEDICAL WEIGHT LOSS. AS A COURTESY, WE WILL PRINT A FORM DETAILING THE SERVICES THAT YOU HAVE RECEIVED AT HFP BARIATRICS THAT YOU CAN SUBMIT TO YOUR INSURANCE. NO GUARANTEE IS MADE OR IMPLIED THAT YOUR INSURNACE WILL COVER THE SERVICES PROVIDED BY ADVANCED MEDICAL WEIGHT LOSS.

PAYMENT IS DUE AT THE TIME OF SERVICE. IF PAYMENTS IS NOT MADE AT THE TIME OF SERVICE, THEN A $17.00 BILLING FEE WILL BE CHARGED TO YOUR ACCOUNT. THE UNDERSIGNED JOINTLY AND SEVERALLY AGREE TO PAY THE BILL FOR SERVICES PROVIDED AT THE OFFICE OF HFP BARIATRICS. A FINANCE CHARGE OF 18 PERCENT PER MONTH WILL BE APPLIED ON ANY AMOUNT THAT HAS NOT BEEN PAID WITHIN 30 DAYS FROM THE FIRST ITEMIZED STATEMENT. ACCOUNTS THAT ARE OVER 60 DAYS LATE WILL BE SENT TO AN OUTSIDE COLLECTION AGENCY AND RELEASED FROM HFP BARIATRICS. IN EVENT THAT FULL PAYMENT FOR CHARGES INCURRED ARE NOT MADE, THE UNDERSIGNED AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING ANY ATTORNEY'S FEES, AND INTEREST AT THE RATE OF 18 PERCENT ANNUM. THE UNDERSIGNED ALSO AGREE TO SUBMIT TO THE JURISDICTION OF THE COURTS OF SALT LAKE CITY COUNTY, UTAH. RETURNED CHECKS ARE SUBJECT TO AN IMMEDIATE $20.00 PROCESSING FEE AND WILL BE REFERRED TO COLLECTION AFTER 10 DAYS IF THE AMOUNT OF THE CHECK AND THE FEE AMOUNT ARE NOT PAID AT THAT TIME.

IF FULL PAYMENT FOR PRIOR SERVICES HAS NOT BEEN MADE, VISITS WILL BE RESCHEDULED UNTIL SUCH TIME THAT FULL PAYMENT IS MADE.

SCHEDULING AGREEMENT: THE UNDERSIGNED AGREE TO MAKE EVERY EFFORT TO KEEP SCHEDULED APPOINTMENTS AND ARRIVE ON TIME. APPOINTMENTS THAT CANNOT BE KEPT SHOULD BE CANCELLED 24 HOURS IN ADVANCE. APPOINTMENTS THAT ARE NOT CANCELLED AT LEAST 2 HOURS PRIOR TO THE SCHEDULED TIME WILL BE SUBJECT TO A NO SHOW FEE OF $17.00 - $33.00 DEPENDING ON THE LENGTH OF THE APPOINTMENT. PATIENTS THAT ARRIVE 20 MINUTES OR LATER FOR A SCHEDULED APPOINTMENT WILL BE ASKED TO RESCHEDULE, AND MAY ALSO BE SUBJECT TO A NO-SHOW FEE, TO BE DETERMINED ON A CASE-BY-CASE BASIS. PATIENTS THAT NO SHOW 3 OR MORE SCHEDULED APOINTMENTS IN 1 YEAR, WITHOUT CALLING TO CANCEL THE APPOINTMENT WILL BE REVIEWED AND MAY BE RELEASED FROM THE PRACTICE.

PRIVACY ACT: IN AN EFFORT TO KEEP PATIENT INFORMATION CONFIDENTIAL, ADVANCED MEDICAL WEIGHT LOSS HAS SET FORTH POLICIES THAT ENSURE DISCRETION AND CONFIDENTIALITY FOR ALL PATIENT MATTERS.

THE UNDERSIGNED CERTIFY THAT THEY HAVE READ AND AGREE TO THESE TERMS.

____ ____________________

PATIENT SIGNATURE DATE

____ ____________________

PATIENT OR GUARDIAN SIGNATURE (IF PATIENT IS UNDER 18) DATE