LAKE GROVE
FAMILY MEDICAL CLINIC

Weight-loss Financial Agreement

The following is a financial agreement between you and Lake Grove Family Medical Clinic (LGFMC) that states your financial responsibility as a weight loss patient.

These visits are for weight loss management only. No other concerns will be addressed at this appointments

I will be paying for my services as follows (please initial one):

___ I do not have coverage for weight loss services, I understand I must pay at time of service via cash or credit/debit card. I understand that LGFMC will not retroactively submit a claim to an insurance provider for services rendered.

___ I will be using my medical insurance coverage and understand that LGFMC will only submit one (1) claim per Date-of-Service. No appeals will be made for denied claims. All denied claims are my responsibility and due upon statement receipt.

Late Cancelations/Missed Appointments: We require 24-hours notice to cancel your appointment.

___ I agree to pay for any late cancellation or missed appointment fees and understand that multiple offenses will lead to termination from the practice as stated below:

The first offense costs $50. The second is $75. The third is $100 with termination from the practice.

All fees must be paid for further services.

AUTHORIZATION

By signing below, I confirm that I understand the terms of this agreement and understand that I am completely responsible for all costs associated with all services provided to me, my dependents or any other person for whom I have assumed financial liability.

Patient Name (Printed): _____ DOB: _____

Printed Name of Responsible Party: _____

Signature of Patient/Responsible Party: _____ Date: _____