**WEIGHT LOSS AGREEMENT**

This Agreement is made this\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. **HEALTH CARE SERVICES THAT WILL BE PROVIDED:**

Patient desires to receive a health care program from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_which includes:

**Prepay Special:**

* **$150 startup fee includes 2 weeks of appetite control, 1 provider office visit, labs, and detox program**
* **Genetic testing: $250 Serial# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **$140/month**

(**Retail $496)**

1 provider office visit with appetite suppressant

2 Lipo Plus injections

40% off 12 or more Lipo Plus injections (In office)

2 online nutritional support sessions

10% off labs

IV/Hormone Consult

20% off IV therapy treatments

1 Body composition analysis

4 vibration plate sessions

4 Lipo Laser sessions

* **$190/month**

(**Retail $730)**

1 provider office visit with appetite suppressant

4 Lipo Plus injections

40% off 12 or more Lipo Plus injections (In office)

3 online nutritional support sessions

10% off labs

IV/Hormone consult

20% off IV therapy treatments

1 Body composition analysis

6 vibration plate sessions

6 Lipo Laser sessions

* **$225/month**

(**Retail $1,024)**

1 provider office visit with appetite suppressant

8 Lipo Plus injections

40% off 12 or more Lipo Plus injections (In office)

4 online nutritional support sessions

10% off labs

IV/Hormone consult

20% off IV therapy treatments

2 Body composition analysis

8 vibration plate sessions

8 Lipo Laser sessions

Monthly total of program selected above will be auto deducted from patient’s bank account every 30 days from the date on this agreement. An auto draft form will be filled out and signed by patient. A 3% merchant service fee will apply to each payment.

2. **PAYMENT**

The payment for the care as set forth in Paragraph 1 will be $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient will pay as follows:

□ Paid in full

□ Cash/Check

□ Credit Card: □ Visa □MasterCard

□ Down payment\_\_\_\_\_\_\_\_\_\_, with \_\_\_\_\_\_\_ installments of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (see auto draft form)

3. **PATIENT COOPERATION**

This Agreement assumes full Patient cooperation. This cooperation includes Patient’s agreement to remain active in the recommended treatment program. Failure to do so may result in an incomplete treatment program. Hence, compliance to recommended schedules is equally important and Patient agrees to keep appointments. Patient understands that additional treatments may be necessary due to lack of cooperation, failure to keep appointments, failure to follow exercise recommendations, engaging in activities outlined to be injurious or which may cause additional trauma to the body. Additional treatments due to Patient’s lack of cooperation as outlined above would be in addition to the treatments provided by this Agreement. The Patient understands that Insurance does not cover this service offered today and Patient is financially responsible for the entire payment. Services do not roll over month to month.

4. **REFUNDS**

Cancellation request must be made 15 days prior to the next payment date. No refunds will be given.

5. **SUBSEQUENT INJURIES**

If Patient suffers a new injury, \_\_\_Clinic Name\_\_\_\_\_\_\_\_\_\_will not be responsible for any loss that results from such injury. Patient does retain the right to purchase additional services from \_\_Clinic Name\_\_\_\_.

6. **NO GUARANTEE OF RESULTS**

Patient recognizes this Agreement is not a guarantee of results.

7. **COMPLETE AGREEMENT**

This Agreement constitutes the complete agreement and understanding between Patient and \_\_Clinic Name \_\_\_ and will not be changed or modified in any way unless agreed to by both parties in writing.

**PLEASE READ THIS DOCUMENT CAREFULLY! DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY**.

**PATIENT HAS FULLY READ THIS AGREEMENT AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF ITS TERMS.**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_