INSERT LOGO HERE

**SERVICE AGREEMENT – Weight Loss**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip: \_\_\_\_\_\_\_

Weight Loss Package \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retail \_\_\_\_\_\_\_\_\_\_\_ Discounts \_\_\_\_\_\_\_\_\_\_\_ Tax \_\_\_\_\_\_\_\_ Total \_\_\_\_\_\_\_\_\_\_\_\_\_ Down Payment \_\_\_\_\_\_\_\_\_\_\_\_

Balance Remaining \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payment Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Due Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Final Payment Due \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counseling Visits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Provider Visits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appetite Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Water/Potassium\_\_\_\_\_\_\_\_\_\_\_\_\_

HCG Inj 45 23 Other Service(s) Purchased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE FOLLOWING TERMS AND CONDITIONS SHALL APPLY to all Service Agreements between **INSERT CLINIC NAME HERE** (hereinafter “Provider”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (hereinafter “Patient”)

1. Appointments may be rescheduled with not less than twenty-four (24) hours’ notice before the scheduled appointment. Any missed appointments or late shows for appointments without at least twenty-four (24) hours’ notice before the scheduled appointment shall be lost, and a $25.00 fee will apply.
2. All weight loss counseling weeks must be consecutive, or services will be lost. **INITIAL\_\_\_\_\_**
3. Any medications or injections removed from the Provider’s office are neither returnable, nor refundable. **INITIAL\_\_\_\_\_**
4. Any additional medication beyond the 30-day supply is considered a Booster and will be charged at $1.00 per pill. **INITIAL\_\_\_\_\_**
5. Any packaged products still in original sealed container may be returned to Provider for in-office credit only.
6. Patient shall be required to complete a Release of Liability form prior to removing any injection products to be administered by the Patient.
7. If Patient chooses to purchase any Human Chorionic Gonadotropin (HCG) product(s), Patient acknowledges HCG is neither returnable, nor refundable. **INITIAL\_\_\_\_\_**
8. If Patient discontinues their program, any unused products and/or services, must be used within one (1) year of Patient’s last visit or they expire and are null and void. **INITIAL\_\_\_\_\_**
9. Patient gives consent to Healthy Habits, Healthy Habits Management Co. and licensees to use name, photos, video testimony, verbal and/or written statements for local and/or national advertising use to promote their medical weight loss programs. **INITIAL\_\_\_\_\_**
10. Provider cannot guarantee weight loss results if Patient does not follow the program as recommended. **INITIAL\_\_\_\_\_**
11. Any cancellation shall be subject to an administrative fee of $200.00. In addition, any refund shall be calculated based on the full retail price without any discount, prorated from the time used, and paid within thirty (30) days. **INITIAL\_\_\_\_\_**
12. I understand I am financially responsible for all charges. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company. **INITIAL\_\_\_\_\_**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Financial Party (if not the Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_