

**NEW PATIENT AUTHORIZATIONS, ACKNOWLEDGMENTS, & FINANCIAL POLICY**

Please initial that you understand and agree to each item:	
_____	<b>Treatment Authorization:</b> I authorize medical treatment for myself or my minor child by any or all providers and professional staff affiliated with Body Renew, LLC. I understand that Body Renew, LLC is not a primary care provider.
_____	<b>Financial Responsibility:</b> I understand and agree to the following policies regarding financial responsibilities: Payment is required at <u>each</u> visit. Accepted forms of payment: cash, debit and credit cards (Visa, MasterCard, American Express, and Discover). We do not accept checks. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treating physician(s). I also agree to be responsible for costs and expenses, including bank fees, court costs, attorney fees, interest, and other associated fees should it be necessary for Body Renew, LLC to take action to secure payment of any outstanding balance. In the event that any credit card payment does not go through, I agree to pay cash for those charges and acknowledge that I will pay cash for all future services.
_____	<b>Notice to Patients of Non-Participation in Insurance Plans or Medicare:</b> Body Renew, LLC is not a participating provider for any health insurance plans, including Medicare, and will not submit any insurance paperwork for me. I take full financial responsibility for treatments received at the time of treatment.
_____	<b>Notice of Information Practices and Privacy Statement:</b> I acknowledge I have had the opportunity to read this document and understand my rights regarding communication and privacy.
_____	<b>Notice as to Nature of Services:</b> I understand that care I receive at Body Renew, LLC may be non-traditional or unconventional. Such services are commonly referred to as complementary, alternative, holistic, or functional medicine. Some of these services may not be recognized as standard allopathic medical practice and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that prescribed for me.
_____	<b>No Guarantees:</b> I am aware that no practice of medicine is an exact science and acknowledge that there are and can be no guarantees as to the accuracy or outcomes of any diagnoses or treatments I receive. I am aware and acknowledge that much of my care with Body Renew, LLC depends upon my direct involvement and willingness to make lasting changes to my lifestyle.
_____	<b>Appointments:</b> It is our desire to provide excellent care to our patients and make every effort to be on time with appointments. We recognize that your time is very important. We ask all patients to be on time for appointments or to reschedule ahead of time if needed. If you make an appointment and then don't show up, that takes away time we could have spent with other patients and also affects our ability to meet our financial responsibilities. You will receive an automated appointment reminder via email, so please make sure you provide us with any changes to your email address.  I understand that I am fully responsible for keeping track of my appointment dates and times. I promise to be on time for appointments and understand that if I am late for an appointment, even by as little as 5 minutes, I may need to be rescheduled. Should I need to change or cancel an appointment, I agree to call the office <u>at least</u> 24 hours in advance. I agree to pay a fee of \$30 if I fail to give proper notice of cancellation/ reschedule or I have to be rescheduled to another day because of my late arrival. I understand that repeated no shows or late arrivals may lead to me being discharged as a patient from the clinic.

**Revocation of Authorizations:** These authorizations may be revoked by me in writing at any time and will take effect on that day for any visits in the future. Such revocation will not affect my financial responsibility to pay for services rendered or for no-show, late cancellation, or late arrival charges applied to my account.

**By signing below I confirm that I have read and understand all items in this document.**

\_\_\_\_\_  
 Patient's Printed Name

\_\_\_\_\_  
 Signature of Patient or Legal Guardian

\_\_\_\_\_  
 Date