One Body Clinic

FEE FOR SERVICE

MEDICAL AGREEMENT

Patient's Name: _____

1. Medical Consent: I consent to any medical treatments or procedures which may be performed on an outpatient basis (excluding emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of **[One Body Clinic]** assisting my care.

2. Financial Obligation: I understand that all Fee For Service (FFS) charges are due at the time of service. I agree to pay of **[One Body Clinic]** for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. The Fee For Service charges are as follows:

BioIdentical Hormone Replacement Therapy (BHRT)

BHRT First Visit_____$310

BHRT Second Visit_____$195

BHRT Subsequent Visit_____$175

Established Patient Yearly Physical with BHRT management_____$285

Fertility Care/ Cycle Hormone Consult

Cycle First Visit_____$310

Cycle Second Visit_____$195

Cycle Subsequent Visit_____$175

Established Patient Yearly Physical with NaPro management_____$285

3. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. I agree to pay for my visit in full at the time of service.

4. I understand that my insurance policy is a contract between myself and my insurance company and that of **[One Body Clinic]** will not bill or fill claims with your insurance provider for the services rendered under this FFS agreement.

5. Release of Medical Information: I hereby authorize of **[One Body Clinic]** to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in of **[One Body Clinic]** care of the above-named patient.

6. The undersigned certifies that he/she has read and agree to the above and foregoing, and received a copy thereof, and is the duly authorized to enter this FFS agreement

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Patient or Guardian Initials: _____Date: _____