NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not appl to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

CONSENT FOR EXAMINATION AND TREATMENT

MEDICAL

I (we) hereby authorize the providers of *Medical Weight Loss Solutions* to provide such care and treatment that is necessary for my particular case per the decision of the provider in attendance. It is my responsibility to make known any and all contradictions to care I may have, and I assume all responsibility/liability if I do not report my past medical history, illnesses, medicines, allergies, or any health issues that may interfere with my care. Care may include consultation, examination, or Sanexas treatments.

I understand that *Medical Weight Loss Solutions* does not provide traditional care for any medical conditions other than those addressed by my treatment plan. I acknowledge they do not prescribe nor refill any controlled substances or medications unless deemed necessary to complement my care.

Furthermore, I do not expect the providers of *Medical Weight Loss Solutions* to be able to anticipate all risks and complications associated with the kind of care being provided and wish to rely upon them to exercise their best judgment during said course of care. This includes the history and physical exam, any diagnostic test they order, and any procedures deemed necessary and in my best interest. I have had the opportunity to discuss the nature, purpose and risks of medical treatment and procedures provided by *Medical Weight Loss Solutions* and have had my questions answered to my satisfaction. The provider will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the conditions treated at this clinic.

I also clearly understand that if I do not follow the provider's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the provider for all services rendered.

I have read (or have had read to me) the above explanation for treatment and have been informed and weighed the risks involved in such care at this office. I have decided that it is in my best interest to receive care provided by *Medical Weight Loss Solutions*, and I hereby give my consent to that treatment.

PHOTO USE RELEASE FORM

I hereby grant and authorize *Medical Weight Loss Solutions* the right to take, edit, alter, copy, exhibit, publish, distribute and make any use of any and all pictures or video taken of me to be used in and/or for legally promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits, and submissions to journalists, websites, social networking sites, and other print and digital communications, without payment or any other consideration. This authorization extends to all languages, media, formats, and markets now known or hereafter devised. This authorization shall continue indefinitely unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of *Medical Weight Loss Solutions* and will not be returned.

I hereby hold harmless, and release *Medical Weight Loss Solutions* from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

CANCELLATION, NO SHOW, LATE POLICY

Description

"**No Show**" shall mean any patient who fails to arrive for a scheduled appointment without notice.

"**Same Day Cancellation**" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

"**Late Arrival**" shall mean any patient who arrives at the clinic 5 minutes after the expected arrival time for he scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. The *Medical Weight Loss Solutions* goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "Cancellation, No Show, Late Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established patients:
   a. Appointments must be canceled at least 24 hours prior to the scheduled appointment time.
   b. If a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens.
   c. In the event that a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations", the patient may be subject to dismissal from *Medical Weight Loss Solutions*. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with *Medical Weight Loss Solutions* guidelines.

III. New patients:
   a. Appointment must be cancelled at least 24 hours prior to appointment time.
   b. In the event of a no-show, may require a new referral sent from the referring physician.
   c. If a patent arrives late as defined by the "late arrival" to their appointment, *Medical Weight Loss Solutions* reserves the right to request a new referral from the referring physician.
   d. In the event of three (3) documented "same-day cancellations" or "no-shows", the patient may be subject to dismissal from *Medical Weight Loss Solutions*.