

Shawnee Metabolic Management Center Patient Consent and Authorization

CONSENT FOR TREATMENT I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending/collaborative physician(s) and it is the responsibility of the staff to carry out the instructions of such Providers(s).

INSURANCE and PAYMENT Shawnee Metabolic Management Center does not participate with insurance companies. *I, the patient, am responsible for my paying bill in advance of being seen by the provider for all services rendered.* I understand that this is a non-covered benefit for insurance companies. I will not submit any claim to my insurance company. No refunds or discounts based on insurance EOB's will be made. I am required to provide a credit card for my visits to be charged each month, by completing the Authorization Agreement for Preauthorized Payments form. My credit card will be charged the monthly participation fee each month on the first Wednesday of the month. I understand that the initial fee of \$250 to hold my appointment is non-refundable. The first consultative visit will cost a total of \$500 plus the cost of laboratory work and an electrocardiogram and any other testing deemed necessary. Monthly participation fees are \$100/month and will include 1 monthly visit, in person or by teleconference, and email/telephone communication. A minimum fee of \$100 per month will be charged.

NO SHOW I understand that if am required to pay the full amount of my scheduled visit if I do not come in for or am not available for the appointment or if I cancel with less than 48 hours notice.

RELEASE OF INFORMATION SMMC is not a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any release of my medical records will require signed authorization from me, the patient or the patient's legal guardian.

GENERAL RELEASE The SMMC maintains insurance as required by the State of Kansas. *The SMMC's liability to me the patient for any indemnity commitments or for any damages arising in any way out of the performance of this contract is limited to such insurance coverages and amounts. In no event shall the SMMC be liable for any indirect, special or consequential loss or damage arising from the performance of services hereunder including, but not limited to, loss or use, loss of profit, economic damages, guilt and suffering, whether caused by the negligence of the SMMC, or otherwise, and I, the patient shall indemnify (cover) and hold SMMC harmless from any such damages or liability. I, the patient agree to indemnify (cover) SMMC for all attorneys' fees, court costs, and all related expenses incurred by SMMC as a result of any claims made against the SMMC by me, the patient or my agents.* I understand that the waiver includes any claims based upon negligence, action or inaction of its employees. I agree to indemnify (cover) and hold SMMC harmless from sequelae of known medical conditions, outcomes or medications not expressly disclosed to SMMC in writing during my first consultation.

Witness

Date

Patient

Date