



PATIENT AGREEMENT FOR TREATMENT

San Antonio Prime Wellness LLC, is an Insurance Free Entity.

THIS AGREEMENT is made and executed on ____ (day) of _____ (month), 2022, between *San Antonio Prime Wellness* (hereafter called “SAPW”) and _____ (hereafter called “Patient”).

IN CONSIDERATION of SAPW providing Patient with medical management, administrative, and follow-up services, Patient understands and agrees to the following:

Patient understands that he/she will not request SAPW to submit a claim to any third-party payor, even if patient is entitled to benefits, for any portion of the fee or any services rendered to patient. SAPW will not accept assignment from any third-party payor as payment for services. Patient understands that Medicare, Medicaid, and Champus require a waiver that states the patient acknowledges the waiving of rights to file a claim to seek reimbursement from these entities or secondary insurance coverage. _____

MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire or to the Physician(s) of SAPW could result in inappropriate treatment. _____

AUTHORIZATION: Patient authorizes SAPW to obtain, on Patient’s behalf, medical laboratory, diagnostic testing, Physician(s) consulting, and compounding pharmacy supplies. In addition, Patient authorizes SAPW and the Physician(s) to provide medical care and prescribed pharmaceuticals based on the Medical History Questionnaire, laboratory testing, and other information submitted to SAPW under this agreement. _____

INSTRUCTIONS AND TREATMENT: Patient understands and agrees to comply with the method of instruction, treatment and dosage schedules prescribed by Physician(s);to immediately cease any medical treatment prescribed by Physician(s) in the event of an adverse reaction or side effect arising from prescribed treatment;and to immediately provide SAPW and Physician(s) with written notice *via email to saprimewellness@gmail.com* of any such adverse reaction or side effect. Patient understands & agrees that diagnosis and treatment of any medical condition may involve certain risk._____

PRIMARY CARE PHYSICIAN: *Patient represents that he or she is under the care of a primary care Physician and that Patient will not rely or substitute the advice of SAPW Physician(s) should it conflict with the advice of the Patient's primary care Physician. Patient agrees to notify his or her primary care Physician that Patient is receiving HRT.* _____

LABORATORY FEES: *San Antonio Prime Wellness will obtain laboratory testing from certified and registered labs in Texas, including Quest Lab and LabCorp. SAPW will assist the patient in filing laboratory fees to patient's insurance for reimbursement. However, patient understands and agrees that patient's insurance coverage may involve co-pays and/or deductibles, which may require patient to be financially responsible for laboratory fees.* _____

HORMONE REPLACEMENT THERAPY: *Patient understands and agrees that, although each hormone has been approved by the FDA, the FDA only approves or denies usage of products made by manufacturers which are produced in a specific dosage and form. Therefore, the FDA does not approve or disapprove of hormones which are given in an individual dosage or form for each patient by Physician(s) of SAPW. I also understand that Physician(s) may choose to discuss with me and provide medications that are off-label in order to offer the widest range of therapies possible. Off-label prescribing is a common and legal practice by most physicians in the US whereby medications are prescribed for purposes other than originally approved.* _____

WARRANTY: *Patient understands and agrees that the methods of medical treatment offered by SAPW and Physician(s) are not accompanied by any claims, guarantees, or warranties. This agreement remains in effect until revoked by Patient in writing, and photocopies of this assignment shall be construed as valid as the original.* _____

EMAIL COMMUNICATION: *Patient understands and agrees that SAPW offers communication via email for non-urgent matters such as lab results. Although SAPW has implemented reasonable technical safeguards, SAPW cannot guarantee privacy, security, or confidentiality of emails sent or received. SAPW is not responsible for emails that are lost due to technical failure during composition, transmission, or storage. SAPW will not forward emails to third parties without your prior written consent, except as authorized or required by law. Until new technologies are adopted by NDWC, patient understands and agrees that email communications are not encrypted. SAPW RESPECTS AND PROTECTS THE PRIVACY OF OUR PATIENTS. SAPW WILL NEVER SELL OR RENT YOUR EMAIL ADDRESS TO THIRD PARTIES. You may discontinue receiving emails as a means of communication by sending an email or letter to SAPW.* _____

RESCHEDULING: *If patient needs to reschedule or cancel appointment, he/she agrees to notify San Antonio Prime Wellness within 24 hours of scheduled appointment. Patient understands that failure to do so, regrettably, will result in a \$100 "no-show" fee.* _____

Patient Printed Name

Patient Signature

Date