CONTRACT FOR TREATMENT

DFW Anti-Aging and Wellness Centers

Name_____ **Date**_____

I authorize DFW Anti-Aging and Wellness Centers and staff physicians to conduct all necessary treatment required for a comprehensive evaluation that includes history and physical examination; blood or saliva testing; and a plan of treatment customized for me. I confirm that the medical information completed and submitted by me is true and accurate to the best of my knowledge.

I acknowledge that the DFW Anti-Aging and Wellness Centers consultations, physical examinations, and laboratory evaluations are strictly for the diagnosis, treatment, care, and prevention of possible health risks. I reserve the right to use this knowledge in the healthcare of my own body in any legal manner I choose, including the recommended DFW Anti-aging and wellness centers treatment plan. I recognize that DFW Anti-Aging and wellness centers offers and provides Wellness plans that are not necessarily acknowledged, approved, or rejected by other traditional medical professionals or the FDA.

I understand that DFW Anti-Aging and Wellness Centers provides only consultative medical care for wellness and prevention of disease, and I agree to be responsible for having and maintaining my own primary care physician at all times to manage my health care needs that are not provided by DFW Anti-Aging and Wellness Centers.

DFW Anti-Aging and Wellness Centers is an Insurance Free Entity

I understand that I am responsible for all costs of treatment(s) provided by DFW Anti-Aging and Wellness Centers I understand that DFW Anti-Aging and Wellness Centers has elected not to submit claims for any services I receive to any Third Party Payer Program, even if I am entitled to those benefits. I agree not to request submission of claims to any Third Party Payer Programs by DFW Anti-Aging and Wellness Centers for any portion of the fee or for any services rendered to me. DFW Anti-Aging and Wellness Centers will not accept assignment of Third Party Payer Benefits as payment for services. At visit, I may be provided with an Encounter Form.

That provides an itemized statement of services rendered and payments received. Submission of claims to my insurance company may be done on my own accord. If medical records are requested by my insurance company, I will provide DFW Anti-Aging and Wellness Centers the appropriate authorization to release my records, and will pay all fees related to records release. If the claim(s) is denied by my insurance company, I acknowledge that DFW Anti-Aging and Wellness Centers is unable to provide additional assistance to further assist with my claims appeal process.

<u>I understand that Medicare, Medicaid, and Champus require a waiver that states I am waiving my rights to file my claim and seek reimbursement from these government entities or any insurance coverage secondary to any of these entities.</u>

I understand that no warranty or guarantee, either expressed or implied, has been made to me as to results or cure of any health conditions. This agreement will remain in effect until revoked by me in writing and a photocopy of this assignment shall be considered as valid as the original.

If I need to postpone or cancel my appointment, I agree to notify DFW Anti-Aging and Wellness Centers at least 24 hours prior to my scheduled appointment. I understand that failure to do so will result in a late cancellation fee of $100.00.

I have read and understand the instructions, and agree with the above terms and disclaimers of DFW Anti-Aging and Wellness Centers.

Signature_____ Date / Time _____

Witness_____ Date / Time _____