HENDRICKS FOR HEALTH
THE CENTER FOR WEIGHT MANAGEMENT

PERSONAL INFORMATION

LEGAL NAME: _____

BIRTH DATE: _____ **If 65 or older, please sign Medicare Contract on back**

ADDRESS (No P.O. Box):_____

CITY/STATE: _____ ZIP: _____

CONTACT TELEPHONE: _____(Cell/Home/Work) ALTERNATIVE: _____

Join Our Email List! Want to be informed of the latest nutritional information, specials, new products and health tips?

EMAIL: _____

APPOINTMENT CONFIRMATION PREFERENCE (check all that apply): ____ Phone Call ____ Email ____Text

OCCUPATION:_____ DO YOU TRAVEL FOR WORK: ____ Yes ____ No

No-Show Policy: No-show appointments will be subject to a $25.00 charge payable at next appointment. *Initials* ☐

DO YOU RECEIVE MEDICARE BENEFITS? **Yes or No If receiving Medicare benefits, please sign Medicare Contract on back.**

Circle how you heard about us, all that apply:

Our Website / Our Sign / Facebook / Yelp / Instagram / Magazine / Yellow Pages / Advertisement / Television / Obesity Medicine Assoc.

Doctor (Name): _____

Patient (Name): _____

Please hand us your Drivers License to be copied

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

1) NAME: _____ RELATIONSHIP: _____ TELEPHONE: _____

2) NAME: _____ RELATIONSHIP: _____ TELEPHONE: _____

PRIMARY CARE PHYSICIAN: _____ MEDICAL INSURANCE _____

PLEASE LIST ALL PERSONS YOU AUTHORIZE *Hendricks for Health* TO RELEASE HEALTH-RELATED RECORDS; TREATMENT, FINANCIAL DOCUMENTS AND APPOINTMENT INFORMATION, TO WHEN NECESSARY.

1) _____ 2) _____

PLEASE READ AND SIGN BELOW IF YOU UNDERSTAND AND AGREE WITH THE FOLLOWING STATEMENT:

Ed J.Hendricks, MD is not a Medicare "Provider," nor is he a "Provider" for any health insurance program. Neither Medicare nor MediCal will cover weight control services, although Medicare will pay for Bariatric surgery. We do not bill insurance carriers for services or products, but will provide an insurance receipt for potential reimbursement by your insurance carrier. Therefore, I acknowledge that I am financially responsible for charges incurred at each appointment and for immediate payment.

SIGNED: _____ **DATE**: _____

MEDICARE PRIVATE CONTRACT

This agreement is between Dr. Ed J. Hendricks, M.D. ("Physician"), whose principal place of business is 2510 Douglas Blvd, Suite 200, Roseville, CA 95661 and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on June 17, 2015 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient any and all medical services pertaining to the management of excess fat accumulation, overweight, and obesity and including any disease or condition that may be associated with these processes.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to Dr. Hendricks' then current fee schedule Fee Schedule of which I have been informed. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on [date]_____by [Patient name] _____

Patient signature: _____

and by Ed J. Hendricks, M.D. [signature]_____