LEAN MD
MEDICALLY SUPPORTED WEIGHT LOSS

The Better Weigh Center| 5826 Esplanade Drive Suite 102| Corpus Christi, TX 78414| P: 361-500-2898

Statement of Financial Obligations

Patient Name: _____ Date of Birth: _____

I agree to pay-in-full the prices stated herein for all visits and purchases under the LeanMD Weight Loss Program in accordance with this Statement of Financial Obligations. Furthermore, I understand, acknowledge and agree to **The Better Weigh Center** facilitating (1) my execution of this Statement of Financial Obligations for the benefit of LeanMD, and (2) my payment of all amounts for visits and purchases under the LeanMD Weight Loss Program.

Weekly Prepayment Program ("Loss")

$50/75 per week, paid by weekly recurring auto payment for consecutive weekly weight loss visits.

- Upon enrollment into the program the Practice Medical Provider will:
  - Take a survey of your complete health history,
  - Perform an Electrocardiogram (EKG) if deemed medically necessary,
  - Conduct a focused physical examination, review the need for baseline testing (bloodwork, cardiac testing, etc.), and
  - Provide a one-month supply of initial consultation nutritional supplements (additional supply must be purchased separately).
- On an ongoing weekly basis:
  - You will attend follow-up visits (virtual or in office) with a LeanMD Mentor, who will analyze your body composition,
  - You will be eligible to receive Lipo B12 injections (when in office),
  - You will have access to Loss and Transition phases of the LeanMD Mobile App,
  - The Practice Medical Provider will evaluate your suitability to receive appetite suppressant medication, and
  - The Practice Medical Provider will monitor your need for follow-up laboratory and testing studies.
  - Both billing and program to commence upon enrollment.

Monthly Weight Maintenance Program

Sustain Program - Available once weight loss goal is attained

$50/75 per month, paid by monthly recurring auto payment for consecutive monthly weight maintenance visits.

- On an ongoing monthly basis:
  - You will attend follow up visits (virtual or in office) with a LeanMD Mentor, who will analyze your body composition,
  - You will be eligible to receive Lipo B12 injections (when in office),
  - You will have access to the Sustain Phase of the LeanMD Mobile App and virtual monitoring of body weight from home via the LeanMD Bluetooth Scale (Scale to be purchased separately), and
  - The Practice Medical Provider will monitor your need for follow up laboratory and testing studies.
- Monthly Maintenance members will have access to the Rapid Rebalance Program, which includes one free week of the weight loss program per year.
  - Both billing and program to commence upon enrollment.

Additional Financial/Program Information

- Fees for supplies and LeanMD nutritional supplements are due and payable at the time of purchase.
- Any laboratory or other medical testing to be conducted at the advice of the Practice's Medical Provider will be subject to additional fees chargeable by the Practice (not by LeanMD), for which you shall be solely liable.
- If you choose to pay for Loss program or Sustain program by check:
  - We may require you to submit a credit or debit card and authorize the Practice to satisfy any outstanding balance by charging the credit or debit card if your account is not paid in full when due.
  - You must pay in advance on a monthly basis for the Loss program, which requires a recurring monthly payment by check of $ 00.00 .
  - You must pay in advance on an annual basis for the Sustain Program, which requires one annual payment by check of $ 00.00 .
  - A $35 fee will be assessed for any returned check; thereafter, check payments will no longer be accepted.
- **All payments mentioned in this agreement are non refundable and will not be not be held, extended, prorated, credited or refunded for any reason, including but not limited to missed appointments, quitting the program or re-enrolling in the Weight Loss Program.**

Terminating the Weight Loss Program

- To terminate any monthly program you must notify us in writing. We require 30 days' notice prior to any such termination.
- Please be advised that if you continue to use the Mobile App and Bluetooth Scale to weigh in or track your weight manually, these transmissions will continue to be sent to your practice for purposes of monitoring your progress, prompting you to re-enter the program, or directing or recommending alternative treatments to you, even after you have terminated the LeanMD program.
- If you wish to discontinue these transmissions, please do not use the LeanMD Mobile App for monitoring your weight.

Prescription Appetite Suppressants

See Practice's Prescription Appetite Suppressant Info Form attached to this Statement of Financial Obligations.

I understand that services may or may not be reimbursed by insurance, and that the Practice does not bill insurance companies for Weight Loss Program fees, Supplies, Supplements or Services. I understand that the Practice cannot guarantee reimbursement and that I am financially responsible for all charges, whether or not paid by my insurance carrier. I understand that the Practice does not and will not handle additional correspondence with insurance companies (i.e., no letters, faxes, phone calls, additional forms, etc.). The Practice may, at its discretion, provide invoices, letters of medical necessity, and CMS forms to patients for their use. The Practice will not alter or enter diagnosis or procedure codes unless medically justified. Obesity or Overweight will always be the primary diagnosis. I may contact my insurance company to explore reimbursement independently and/or contact my benefits administrator to see if services are covered under a Health Spending or Flexible Spending account. I may also consult my tax advisor to see if LeanMD services qualify as deductible medical expenses. I acknowledge and agree to all of the above.

By entering into the LeanMD Weight Loss Program I also consent to the wireless transmission of my weight through the LeanMD Wireless e-Scale to a secure website where the Practice can access it for purposes of monitoring my progress, treating me, prompting me to re-enter the program or directing or recommending alternative treatments, therapies, health care providers, or settings of care to me.

Payment Authorization

I hereby authorize the Practice to charge my credit/debit account weekly for the Loss program fees, and monthly for the Sustain program fees until such time that I officially withdraw from the program.*

I authorize the Practice to satisfy any outstanding balance on my account by charging my credit/debit card if my account is not paid in full when due.*

_____ **(Initial here if you marked the 1st box)** I have provided the Practice with my credit/debit account for payment processing using the Lean MD Point of Sale System.

* I hereby authorize the Practice to charge, or to initiate transfers from, the credit card and/or bank account entered into the Lean MD Point of Sale System or from any account I provide from time to time for the purpose of making the payments which I owe to the Practice each week or month based on the respective LeanMD program in which I am enrolled or participating ("Program") until all of my obligations (and related fees, taxes and charges, if any) are paid under this Statement of Financial Obligations agreement (SFO), or until I officially withdraw or terminate the Program. I acknowledge that I have provided my credit card and/or checking account information to the Practice and that I shall maintain a current credit card or checking account at all times. I understand that my obligations under this SFO agreement includes monthly payments, applicable taxes, charges and any other unpaid fees or amounts due to the Practice. This authorization will remain in full force and effect until cancelled by the Practice, or until the Practice receives my written revocation. I understand that I may stop any ACH Debit (checking, savings, debit card) by notifying my financial institution at least three (3) days before the scheduled date of the transfer. Cancellation or revocation of this authorization, or stopping any payment hereunder, does not affect any other payments authorized on the date of this agreement or in the future. I understand and acknowledge that the amounts debited to my account may vary each month between the amount shown above, and three times that amount, due to past unpaid amounts, applicable taxes, and other fees and charges. I understand that I have the right to receive notice in writing at least ten (10) days in advance of any ACH Debit (checking, savings, debit card) that will fall outside of this range. I confirm that I am authorized under the terms of the applicable agreement with my financial institution (the "Bank Agreement") to use the account I have designated for the payment for program-based fees and for the purchase of goods and services from the Practice. I certify that all statements made in this payment authorization are true and correct to the best of my knowledge. I understand that any failure by the applicable financial institution to pay any charge in full does not release me from any liability for obligations owing to the Practice. I agree to comply with my Bank Agreement at all times that this authorization is in effect.

Signature | Print Name | Date