Consent to Treatment

Please read carefully and acknowledge your acceptance by providing your signature.

I authorize Anti-Aging & Wellness Atlanta to perform a comprehensive analysis including consultation, history & physical (H&P), serology testing and develop for me a recommended treatment plan for optimal health. I affirm that the information submitted for evaluation was submitted by me and is true to the best of my knowledge.

I acknowledge that the Anti-Aging & Wellness Atlanta consultations, laboratory blood work, and the physical examination are for the diagnosis, treatment, care, alleviation, mitigation, prevention, and/or care of possible health risks. I reserve the right to use the knowledge I gain in the care of my own body in any legal manner I choose, including the recommended Anti-Aging & Wellness Atlanta treatment plan.

I understand that Anti-Aging & Wellness Atlanta provides consultative medical care for prevention and wellness and agree to be responsible for having and maintaining my own primary care physician at all times to manage health care needs not provided through my center.

I recognize that Anti-Aging & Wellness Atlanta treatment plan is a proactive anti-aging and wellness plan that is not necessarily approved nor rejected by the conservative factions of the medical profession or the Food and Drug Administration.

Anti-Aging & Wellness Atlanta program model is based on the collective experience of licensed physicians with Traditional Primary Care Medicine and Anti-Aging Medicine and promotes proper diet, adequate daily exercise, and hormonal balance using bio-identical hormones, nutritional supplementation (IV/PO) and the early detection and/or prevention of disease.

Insurance Consideration

I understand that I am responsible for all costs of treatment(s) provided by the Anti-Aging & Wellness Atlanta. I understand that Anti-Aging & Wellness Atlanta cannot guarantee that services will be covered by my insurance company. At each visit, I will be provided an itemized statement of services rendered and payments received. Submission of claims to my insurance company is done on my own accord. If medical records are requested by the insurance company, I will provide Anti-Aging & Wellness Atlanta the appropriate authorization to release records. If the claim(s) is denied by my insurance company I understand that Anti-Aging & Wellness Atlanta is unable to provide additional assistance to further assist patients with their claims appeal process.

Please know that if you are eligible for Medicare, Medicaid or Champus, you must sign a waiver. This waiver is required by these government agencies and indicates that you understand that you are waiving your rights to file your claim to and seek reimbursement from Medicare, Medicaid or Champus or any insurance coverage secondary to any of those.

I also authorize the Anti-Aging & Wellness Atlanta to use pertinent information from my questionnaire for outcome measurement and service improvement. I understand my contact information will remain private and will not be shared with any outside organization unless I provide written request.

I have read and understand the instructions and agree with the above terms and disclaimers of the Anti-Aging & Wellness Atlanta.

_____ _____

Signature Date

_____ _____

Anti-Aging & Wellness Atlanta Representative Date