The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: (M / F)
SSN (Required for Weight Loss Program):_____ Birth Date:_____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Best number to reach you: _____

E-mail appointment reminders: _____Yes _____No
Text message appointment reminders: _____Yes _____No ****Cell # provider:** _____
E-Newsletter & Promotions: _____Yes _____No
Email: _____
(You will receive a welcome e-mail or text from us to confirm your appointment reminder preference)

Employment Information:
Employer: _____ Occupation:_____
Phone: ( ) _____ ext: _____
In Case of Emergency:
Name: _____ Relationship: _____ Phone: ( )_____

How did you hear about us?

- □ Magazine
- □ Physician Office
- □ Newsletter
- □ Referral by Current Patient
- □ Sign/Location
- □ Seminar
- □ Coupon Book
- □ Gyms
- □ Local Salon/Spa
- □ Radio advertising
- □ Television
- □ Internet Promotion
- □ Facebook
- □ Website
- □ Internet se

Financial Policy:

Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

No Show or Cancelled Appointment Policy:

We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Lipotropic injections missed cannot be credited for future injections. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy

If you purchase an aesthetic treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature: _____ Date: _____

The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)
___ Face
___ Neck
___ Chest
___ Hands
___ Arms/forearms
___ Legs

Removal of fine lines and wrinkles
___ Full face
___ Forehead
___ Crow's feet
___ Lower face
___ Neck
___ Face and neck

Facial veins/Broken Capillaries/Rosacea
___ Full face
___ Mid-face
___ Nose/Cheeks
___ Lower face

Skin Care Services (other)
___ Microdermabrasion
___ Chemical Peels
___ Micro-Needling
___ Skin Rejuvenation
___ Hand Rejuvenation
___Double chin/Jowls/Eye Fat pads
___Aesthetic VIP Membership

Wellness Testing
___ Metabolic Testing & Evaluation
___ Nutritional Testing & Evaluation
___ Food Sensitivities Testing & Evaluation

Medical Fitness
___Private Fitness Session
___Group Training Classes
___Pre-Natal Exercises
___Yoga Classes

Injectable Fillers (Juvederm/Restylane/Radiesse)
___ Lip augmentation
___ Smile lines
___ Marionette's lines
___ Smoker's lines
___ Volume correction-cheeks/mid- face
___ Lower lids/sunken eyes

Pulsed Light Hair Removal
___ Neck
___ Back
___ Chest
___ Abdomen
___ Underarms
___ Forearms
___ Upper arms
___ Beard (male)
___ Bikini Line
___ Full leg
___ Half Leg
___ Upper lip/chin

Botox
___ Frown lines
___ Forehead lines
___ Crow's feet
___ Smoker's lines
___ Nose lines
___ Neck bands/wrinkles

Hormone Replacement Therapy
___ Hormonal imbalance
___ PMS
___ Pre-menopause
___ Menopause
___ Post-menopause
___ Thyroid Disease
___ Low Testosterone

___**Weight Loss Management**

The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

Hormone Replacement Therapy Questionnaire

- **Personal Data:**

Name _____DOB_____
Gender □ Female □ Male Age_____ Last Physical/Blood Test _____
Primary Physician's Name: _____Office Number: _____

- **Personal Medical History:**

Do you or have you ever had any of the following?

☐ Heart Disease	☐ Bacterial/viral/fungal infection	☐ Celiac Disease
☐ High Blood Pressure	☐ Arthritis	☐ Blood Disease
☐ High Cholesterol	☐ Headaches	☐ Alzheimer's Disease
☐ Diabetes	☐ Depression	☐ Liver Disease
☐ Cancer	☐ Anxiety	☐ Neurological Disorders
☐ Thyroid Disorders	☐ Fibromyalgia	☐ Altered Mood Changes
☐ Osteoporosis	☐ Gastric Reflux	☐ Skin Disorders
☐ Asthma/COPD	☐ IBS/Ulcerative colitis/Crohn's	☐ Autoimmune Disease
☐ Migraine Headaches	☐ Allergies (pet, seasonal, food)	☐ Anemia

Do you smoke? □ YES □ NO If yes, how many packs a day _____
Do you drink alcohol? □ YES □ NO If yes, type & weekly intake _____

For women
Age of first menstruation: _____ First day of last menstrual period _____
How many days your period last?_____ How often do you get your period?_____
Are you pregnant or planning to get pregnant? □ YES □ NO
Have you had a mammogram or Pap smear? □ YES □ NO
Are you currently using contraception? □ YES □ NO Name_____
Date of last: Mammogram _____Pap smear _____ Bone Density_____

Medication, Vitamins & Supplements List:_____
_____
_____

Allergies: _____
_____
_____

Surgical History: Please list any surgical procedures and the year _____
_____
_____

- **Family Medical History:** Has anyone in your family had any of the following? Please specify relationship.

☐	Heart Disease	Relationship_____
☐	High Blood Pressure	Relationship _____
☐	Cancer (type)	Relationship _____
☐	Stroke	Relationship _____
☐	Diabetes	Relationship _____
☐	Renal Disease	Relationship _____
☐	Osteoporosis	Relationship _____
☐	High Cholesterol	Relationship _____
☐	Other	Relationship _____

- **Hormone Therapy History:**

Are you currently or have had Hormonal Replacement therapy? □ Yes □ No

If yes, what type of hormones you have replaced or balanced?

□ Estrogen □ Progesterone □ DHEA-S □ Testosterone
□ Thyroid □ Cortisol □ Melatonin □ Pregnolone
□ Cortisol □ Neurotransmitters IgF-1 (a marker for human growth hormone)

- **Present Symptoms:**

As you have aged, have you experienced any of the following?

☐	Decreasing muscle mass or flabbiness	☐	Reduced strength
☐	Increased stiffness	☐	Insomnia
☐	Decreased endurance	☐	Significant weight loss or weight gain
☐	Significant weight gain	☐	Increased body fat
☐	Fluctuations in body temperature	☐	Sensitivity to cold or heat
☐	Night sweats	☐	Mood swings
☐	Irritability	☐	Dryer or thinning skin and hair
☐	Poor sleep	☐	Sleep difficulties
☐	Forgetfulness	☐	Mood changes
☐	Increased anger or irritability	☐	Unexplained depression or anxiety
☐	Alcohol intolerance	☐	Stress

- **Are you experiencing any of the following symptoms? (Neurotransmitters)**

☐	Sadness	☐	Diarrhea
☐	Decreased ability to focus	☐	Intestinal pain or cramping
☐	Anxiety	☐	Constipation
☐	Feeling panicked/frightened	☐	Feeling hyper or revved up
☐	Feeling fidgety or restless	☐	Feeling worthless or hopeless
☐	Feeling unrefreshed or tired	☐	Lack of energy or endurance
☐	Difficulty falling asleep	☐	Decreased interest in daily activities
☐	Difficulty staying asleep	☐	Forgetfulness or poor memory
☐	Gas or bloating	☐	Low sexual desire

- **Check which of these symptoms are troublesome and have persisted over time**

Hormones Women:

- ☐ Hot flashes
- ☐ Urinary incontinence
- ☐ Painful intercourse
- ☐ Foggy thinking
- ☐ Cold body temperature
- ☐ Decreased bone density
- ☐ Thinning hair
- ☐ Aches/Pains
- ☐ Frequent somnolence
- ☐ Decreased height
- ☐ Night sweats
- ☐ Irritability
- ☐ Decreased libido
- ☐ Weight gain
- ☐ Nervous
- ☐ Fatigue
- ☐ Decreased work performance
- ☐ Decreased mental sharpness
- ☐ Decreased energy
- ☐ Urine frequency/urgency
- ☐ Vaginal dryness
- ☐ Sleep disturbances
- ☐ Mood changes
- ☐ Irregular periods
- ☐ Depression
- ☐ Skin dryness

Hormones Men:

Date of last: Prostate exam _____ PSA test _____

- ☐ Decreased sex drive
- ☐ Decreased energy/fatigue
- ☐ Nervous
- ☐ Foggy thinking
- ☐ Cold body temperature
- ☐ Weight gain
- ☐ Aches/Pains
- ☐ Frequent somnolence
- ☐ Decreased mental sharpness
- ☐ Irritability
- ☐ Decreased height
- ☐ Breast enlargement
- ☐ Depression
- ☐ Erection difficulty
- ☐ Prostate enlargement
- ☐ Decreased work performance
- ☐ Weight gain (mid-portion)
- ☐ Loss of muscle mass
- ☐ Sleep disturbances
- ☐ Mood changes
- ☐ Sadness/Unhappiness
- ☐ Hair loss/thinning

- **Are you experiencing any of the following symptoms? (Human Growth Hormone)**

- ☐ Memory problems
- ☐ Weight gain (mid-portion)
- ☐ Increased body fat
- ☐ Decreased energy
- ☐ Unexplained sadness
- ☐ Lack of positive well-being
- ☐ Decreased lean body mass
- ☐ Decreased bone density
- ☐ Decreased strength
- ☐ Low stamina

In your own words, what you would like to get from this program?_____

_____

Patient Printed Name_____Date _____
Patient Signature_____Date _____
MD/NP Signature_____Date _____

To be completed by office staff

Mammogram	Exam received	□ YES □ NO
Pap Smear	Exam received	□ YES □ NO
Bone Density	Exam received	□ YES □ NO

INFORMED CONSENT FOR HORMONAL REPLACEMENT THERAPY

_____ (Patient) and _____ (Physician) hereby enter into this agreement for provision of medical services specified herein ("services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PHYSICIAN agree as follows:

1. _____ and its PHYSICIANS are responsible for the evaluation and prescription of hormone replacement therapy, indicated by the history, physical examination and laboratory parameters. All costs including physician services and laboratory if indicated are to be paid in full by PATIENT, to the PHYSICIAN, at the time services are rendered.

2. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN and the PHYSICIAN has provided the services specified herein to the PATIENT.

3. The PATIENT acknowledges and agrees that this agreement has not been entered into at the time when the PATIENT is facing an emergency or an urgent health care situation.

4. The services to be provided to the PATIENT are: evaluation of medical history, performing diagnostic tests and providing anti-aging and hormone-balancing replacement therapy.

5. The PATIENT agrees to be responsible for the SERVICES. Our office does not accept insurance plan payments. We are a fee-for-service office. Patients are responsible for payment in full for services rendered to them. Methods of payment include cash and major credit cards (Visa, MasterCard and Discover). Payment is due at the time of the service.

6. Hormone replacement therapy is medical treatment; even though some insurance companies have not yet accepted this position. At this point in time, PHYSICIANS cannot assure the PATIENT that their insurance company will reimburse for preventative care or anti-aging or hormone-balancing replacement therapy. An appropriated statement of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for these purposes may or may not correspond to the codes used by the insurance companies. Changes to the codes will not be made for the use of any insurance company. Insurance may reimburse patients for expenses related to some of the medical services. Reimbursement will not be made from the insurance company to the physician. Please note that The Aesthetic & Wellness Center will not present a bill to any insurance company for services provided or related charges.

7. The PATIENT agrees to check with insurance plan for the correct self-billing instructions and appropriate forms. It is advised to make copies of all forms prior to submitting insurance claims. We are not responsible for denials, non-payments by your insurance company, or filing appeals to insurance companies.

8. The PATIENT acknowledges that health insurance plans such as MEDICARE or MEDICAID will not provide reimbursement for the SERVICES and that no fee limits will apply to the amounts PHYSICAINS charge for their SERVICES. If you are covered by Medicare, then you must complete and sign ABN form prior to participating in the program.

9. The PATIENT acknowledges that some insurance companies may not cover prescriptions called on to a compounding pharmacy therefore the compounding pharmacy will call you directly for a method of payment prior to shipping.

10. The PATIENT acknowledges that some insurance companies may not cover the cost for some of their hormonal testing required. The PATIENT will be responsible for the payment of the blood tests not covered. If PATIENT does not have insurance, we have negotiated with the lab a reduced price starting at $300 and up. No refund can be given once lab test have been performed. Once hormonal imbalance has been stabilized, patients must have bi-annual blood work and follow-up visits in person for the prescriptions to be filled. Lab results will be reviewed and discussed with you during your follow-up visit.

11. The PATIENT acknowledges that prescription refills are called in within 72 hours of the request. After stabilization of hormonal imbalance, prescriptions will be provided for a three month period. Patients, who have been seen bi-annually, may need to be reevaluated before a prescription is called in. Prescriptions for hormones like estrogen, progesterone and testosterone and average $40 or more each per month per hormone.

12. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS, for whom payment may be made under health insurance plans or MEDICARE. We do not assume the responsibility for treatment of major medical illnesses that you are currently being cared for by your primary physician or other care provider. Please continue treatment with your primary care OB/GYN for routine medical problems. We do not provide or complete disability or physical exams form for patients who desire there services. Your primary care physician must complete these forms.

13. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is “health insurance fraud” or any medical treatment not deemed “medically necessary” by Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as “medically necessary” and, therefore, could be interpreted as fraudulent.

14. I have read and fully understand the information above related to the insurance and participation in The Aesthetic and Wellness Center services. I have also had the opportunity to ask questions regarding the information included above. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of this receipt and limitations as described in this document. I accept these specific policies as written. The above information is true to the best of my knowledge. I am satisfied with the information provided during my consultation. I understand the nature of this procedure and treatment, and all my questions to this date have been answered completely. I have read and understand the consent above. I hereby affix my signature to this authorization for this proposed long-term treatment. I have been given and copy of this consent form.

_____ _____

Patient Signature Date

Consent for the Evaluation and Treatment for Hormone Balancing Therapy

I, _____ authorize and give consent to Inda Mowett, M.D. and other physicians, associates and any other healthcare personnel for the evaluation and treatment of my aging process by the administration of hormones, other pharmaceutical interventional therapies and dietary supplements, and any other therapeutic agents in this document. The goal and possible benefits of this therapy are to try and stop, slow and/or reverse my aging process, through hormonal balancing, control of oxidative stress, and other clinically significant therapeutic agents.

I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

Off Label Use

_____I have been completely informed, and I am totally satisfied with my understanding, that the proposed treatment may involve the use of prescription medications such as hormones that have been approved by the Food and Drug Administration (FDA) for medical conditions, other than the slowing, stopping and/or reversing of the aging process.

General Risks

_____I understand and am completely satisfied that the general risks of this proposed treatment and therapy include, but are not limited to, fluid retention or edema, hair loss, hair growth, enlarged breasts, gastrointestinal symptoms, drowsiness, acne, irritability and mood changes. If treatment is provided as an injection, is possible you may experience soreness or pain and possible infection at the injection site.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure and treatment; including the proposed therapy for slowing or reversing the aging process, and that it is not even possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known and unknown general risks.

Patient Compliance - Informed Consent Agreement

_____I understand and agree to follow the proposed treatment and therapy as prescribed without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administrating the hormone(s) or other designated therapies that may be prescribed to me possibly more than once daily. I consent to periodically have my blood drawn or urine specimens obtained for laboratory monitoring and analysis. I also agree to take the dietary supplements, hormone preparations and other designated therapies on the schedule that has been individually designed for me, as prescribed specifically in detail. I have completely and faithfully disclosed my complete medical history, all prescription and supplements that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from you, before stopping any of the

prescribed therapeutic regimens or taking any additional preparations that are not suggested or prescribed by Dr. Mowett.

I also understand that the use of "social substances" such as tobacco, "street drugs," and alcohol and other type of otherwise non-described "social substances" may affect my therapy in a significantly adverse manner.

Diagnosis

_____I fully understand that the medical diagnosis of "deficiency and insufficiency" do not apply to my case because such diagnosis may require tests to establish much lower levels, and as such my levels could be considered normal under that standard.

Specific Risks

_____The following are examples of some of the possible specific risks or adverse reactions reported for hormone therapy that may be prescribed for me. Some of these risks and or adverse reactions are for prescription hormones derived from the official Food and Drug Administration (FDA) labeling requirements for these drugs at therapeutic levels in the blood. Therapeutic blood or urine levels of medications are concentrations that show a therapeutic clinical effect when prescribed at designated pharmacological dose. Our goal is to achieve physiologic levels that are set of a 20-year-old person and would be within the "normal" or "average" blood concentrations of that age group. At physiological blood levels, there are not expected to be any significant risks or adverse reactions as long as full medical disclosure is achieved from the patient during the total time of therapy.

I certify that I will notify immediately of any and all possible symptoms, signs, or possible reactions to my therapy.

Your physician may prescribe the following hormones, other medications or nutraceuticals, as follows:

Prescription and Non-Prescription Hormone/Other Suggested or Prescribed Therapies:

- Estrogen

_____A prescription hormone, given as tablets or transdermal cream. Dr. Mowett wants you to be aware of potential risks. HRT has been associated most frequently with the
following medical problems: breast tenderness, fluid retention, vaginal bleeding, acne, headaches, risk of gallstones, enlarge fibroids, thrombosis and irritability. When used without Progesterone in women who still have their uterus, the risk cancer of the uterus and breast cancer could increase. To reduce the risk, Dr. Mowett will prescribe Progesterone.
No long-term studies on the use of bio-identical hormone replacement therapy are available. Risks are based on studies of synthetic conjugated estrogens.

- Progesterone

_____A prescription hormone, given by sublingual tablets, capsules or cream. Most common side effects are breast or nipple tenderness, fluid retention, acne, decreased sexual drive, breakthrough bleeding, mood changes, increased nervousness, gallbladder disease, breast cancer and cardiovascular disease. Recent research suggests a relationship between Progestin and Cancer. Progestin is a synthetic Progesterone and is not the same as natural Progesterone. There has been no research to support the relationship between natural Progesterone and cancer.

- Testosterone

_____A prescription hormone, given by transdermal cream or pellets. Most common side effects are acne, clotting disorders, deepening of the voice, an enlarged clitoris, hair loss, hair growth on the face, changes in sex drive (normally an increase in sex drive), anger or hostility, shrinking in the size of the testicles and reduction in sperm production. Testosterone can increase hemoglobin and hematocrit, increasing the risk of clotting. For this reason, a CBC is repeated on follow-up lab work.
• Testosterone can change anti-coagulant therapy, so those monitoring their INR will need to check this more regularly. Testosterone may decrease blood sugar levels lowering insulin and anti-diabetic oral agents. Adjustments may need to be made in these medications.

- Thyroid Hormone

_____A prescription hormone taken by mouth. Risks/adverse reactions include palpitations, sleep disturbances, excitability, and increased metabolism.

- Dehydroepiandrosterone - DHEA

_____Given by mouth and classified as a dietary supplement. In excess amounts, adverse reactions include facial hair and acne in women, and prostate enlargement in men.

- Human Growth Hormone (HGH) - Somatotropin

_____A prescription hormone given by hypodermic injection or transdermal infusion. Adverse reactions at therapeutic levels include transient high blood sugar (hyperglycemia), development of antibodies to HGH, localized joint pain and fluid retention. This drug
should not be used in patients with a known cancer. These side effects are dose-related and are usually eliminated by adjusting the dosage.

- Melatonin

_____ A dietary supplement given by mouth given to regulate sleep cycle. The major reported adverse side effects are drowsiness, headache, fatigue, nightmares and exaggerated depressive symptoms. Melatonin has been commonly used to alleviate jet lag.

Other Risks

_____It is not humanely possible to list all the possible risks and complication and the variations that may arise in any medical procedure such as hormonal balancing in the individual examples above. Each patient may react differently to treatment. If you experience any other symptom not listed in this document, report immediately to Dr. Mowett or staff.

Alternative Treatments

_____I have been completely informed via informed consent of the existing law. I am totally and completely satisfied with my understanding of the reasonable alternatives to this procedure which include:

- Leaving the hormone levels as they are - and doing nothing
- Treating age -related diseases as they appear clinically and symptomatically.

Other Alternatives

_____Although you have decided upon the proposed treatment to try to stop, slow or reverse the aging process by hormone balancing and other techniques described herein, do not hesitate at any time, to discuss the reasons for the choices of hormones or any other preparations prescribed for you or any other alternatives possibly available. In addition, be sure to ask your physician at all times that may come up concerning your treatment.

Research Study / Photographs

_____ I further consent to the utilization of the results of my progress in any research study performed by Inda Mowett, MD. I understand that my name will not be used and that every effort will be made to protect my privacy. I also understand that photographs taken of me by will not be used without my expressed permission. I understand that I may suspend or terminate my treatment at any time, upon informing physicians in writing via returned mail receipt requested.

_____ _____

Patient Signature Date

The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

NOTICE IN ADVANCE OF SERVICE TO PATIENT THAT SERVICE MAY NOT BE COVERED BY MEDICARE OR OTHER INSURANCES

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determined that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for all the blood/diagnostic tests ordered by physicians and the cost for the hormone replacement/balance therapy for the following reasons:

1. The tests and treatments are preventative.
2. The tests and treatments are "not reasonable and necessary" for maintaining health or the prevention of disease according to Medicare law guidelines.

_____ _____

Patient Name Date

Beneficiary Agreement:

I have been notified by Dr. Mowett and her associates that they believe that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Beneficiary Signature Date

The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____
Patient Name:_____DOB:_____

May we leave the following types of messages at your home, work, cell phone number, personal email or:

1.	Office appointment reminders/changes	Yes	No
2.	Labs and/or outpatient test results	Yes	No
3.	Payment requirements for upcoming appointments	Yes	No
4.	When authorization, medical records, other info needed	Yes	No
5.	Prescription refill information	Yes	No
6.	Receive office emails to my personal email account	Yes	No
7.	Receive my before and after photos to my personal email account	Yes	No

---

Acknowledgement of Receipt of Notice

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPPA form at our website wwww.tawcenter.com under office forms tab. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Inda Mowett, MD with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

_____
Signature & Date

My healthcare information may be shared with the following persons:

_____
Name & relationship to patient

_____
Name & relationship to patient

No, my records may not be shared _____

The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

Attendance and Cancellation/No Show Policy

Dear Valued Patient/Client:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are in effect for recurrent tardiness and missed appointments

- **24 hour advance notice** is required when cancelling an appointment. This allows for someone else to schedule an appointment during that time. If you are unable to give us 24 hours advance notice you will be charged $25 for your missed appointment, including voicemails left with l**ess** than 24hour notice. This amount must be paid prior to your next scheduled appointment or charged to your credit card on file.

- **Payment Method** - Visa, MasterCard, Discover, American Express and cash. Checks are not accepted.

- **No-shows**
  Anyone who either forgets or consciously chooses to miss their scheduled appointment for any reason will be considered a "no-show." They will be charged $25 for their "missed" appointment.

- **Late Arrivals**
  If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your appointment may to be rescheduled. Regardless of the length of the treatment actually given, **you will be responsible for the payment of the "full" session**. **Please** plan accordingly and be punctual.

- **No Refunds**
  No refunds will be issued for deposits made if cancellation was not received within 24 hours before scheduled appointment. There will be no refunds provided for unused portions of a weight loss program. Medication and lipo injections are also non-refundable and non-transferable

- **Pre-paid cycles**
  Weight loss patients who have pre-paid for a cycle and have to cancel with notice a scheduled appointment will receive credit towards the next month's payment. Unused weeks will be reconciled at the weekly rate

Sincerely,

Inda Mowett, MD

By signing below, I authorize TAWC to charge the account $25 for cancelling or no show for my schedule appointment. I understand that TAWC may continue to charge my account if time after scheduling an appointment I do not notify the office 24 hour prior to my visit. Or cancel my membership in accordance to the terms, rules, regulations and conditions of this agreement. Additionally, I authorize TAWC to charge my credit/debit card on file in lieu of receiving additional services, at my request. You acknowledge receiving and reading a copy of this agreement.

I hereby authorize TAWC to keep swiped credit card information on file and to charge this card if necessary in accordance with the terms of this agreement.

_____ _____
Print Name Date

_____ _____
Signature Date