مركز التعافي الطبي
Wellbeing Medical Centre

Please print clearly

Program Application & Agreement

Last Name: .... First Name: .... Age: ....

Address: .... City: .... Zip: ....

Phone: .... Other: ....

Referred by: .... Occupation: ....

Contact in case of emergency: ....

I agree and understand fully to the following:

I consent for treatment and for guidance on this program. I will follow the program the way that it is designed or modified by the health professional. I will continue with the program until I reach the desired results that I want. I agree to come in for my weekly consultations on time, and understand that any missed appointments will be deducted from my program.

__________(Patient Initial)__________(Physician)

To not stop, quit, or give up with health program. I will be honest with myself. I agree not to cheat, or do things that are not in alignment with the program.

__________(Patient Initial)__________(Physician)

I will work with the health professional to get the best results I can. I agree that I may need further testing (blood, urine, saliva, hormone...etc.) to improve mu health and to customize my treatment program.

__________(Patient Initial)__________(Physician)

I know that my health professional is working on my case during the visit and after, and may seek other professional advice for consultation. I realize that there are many costs involved with this program that I am not aware of. These costs include the costs of supplies, consultation time, chart and progress review, initial consultation fees, actual fees of the program, and any other related office expenses.

__________(Patient Initial)__________(Physician)

I understand that no promise or guarantee has been made to me as to result or cure, and will not hold the physician responsible for my individual result(s) of the treatment(s) that I have requested. I fully understand that there are other alternative treatments available.

__________(Patient Initial)__________(Physician)

I understand that once I have started my treatment program there are no refunds. I understand that my treatment program must be completed within 12 months from date of purchase. I also understand that my program is not transferable.

__________(Patient Initial)__________(Physician)

I also understand that I undertake this program entirely at my own risk and my health practitioner will endeavor to take all due care. I understand that the physician will rely on statements made by me to determine that the procedure is safe and effective for me. I have informed the physician of all my known physical conditions, medical conditions and medications. I assume all responsibility and liability for any condition(s) I have failed to disclose. I choose to do this of my own free will.

__________(Patient Initial)__________(Physician)

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Patient Signature Date Health Professional / Physician