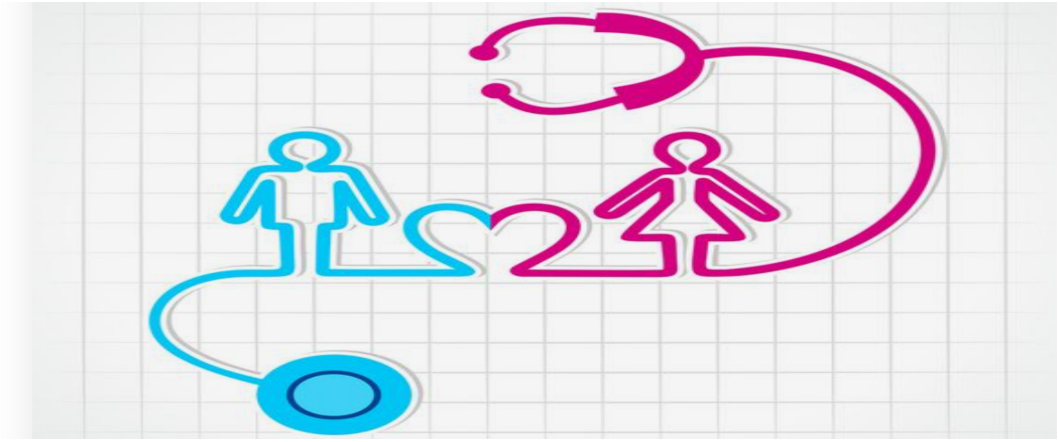

Healthy Living Medical Clinic

Patient Consent for treatment. Please initial and acknowledge each point.

_____Health insurance typically does not cover services provided at Healthy Living Medical Clinic. If you would like to submit to insurance, we can provide you with an invoice that you can submit to an insurance company

_____ I understand that treatments at Healthy Living Medical Clinic might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through aesthetically, nutritional and supplemental counseling, and possibly weight management and hormonal optimization.

_____ I am voluntarily requesting treatment with Healthy Living Medical Clinic and Christine Schiller DNP. Treatment modalities are determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines.

_____ I agree that Healthy Living Medical Clinic (Christine Schiller, DNP) is not my primary care provider unless I elect them. I agree that I will continue primary care through my primary care provider and notify them of treatments prescribed through Healthy Living Medical Clinic.

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed or used per state regulations.

_____ I acknowledge that I have been advised of the risks and benefits. I also acknowledge that I have been advised of possible complications and side effects.

_____ I understand the results of treatment vary from patient to patient and no outcome can be guaranteed. I am fully responsible for payment in full and am responsible for payment regardless of results.

I have read, understand and agree to all of the above statements.

Print name: _____
Date:_____

Signature _____

Witness Name: _____

Signature _____

Date