**Informed Consent For Care**

I hereby request and consent to the performance of medical, surgical care, and treatment as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical, surgical treatment or procedures, or other services rendered to the patient under the general and special instructions of the patient’s physician.

I understand that, as in the practice of medicine, in the practice of medical care, there are some risks to treatment, including but not limited to, fractures, disc injuries, burns, bruising, nerve injuries, dislocations and sprains. I do not expect the providers to be able to anticipate and explain all risks and complications. I wish to rely on the provider to exercise judgment during the course of the procedure(s) which the doctor feels at this time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the providers, affiliated with Rational Longevity Medicine & Wellness to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient’s Printed Name

Patient or Guardian’s Signature

Date

**Financial Responsibility Statement**

I fully understand that I am directly and fully responsible to Rational Longevity Medicine & Wellness for all bills submitted for services rendered to me, and that this agreement is made solely for Rational Longevity Medicine & Wellness’s additional protection and in consideration of awaiting payment.

**Cancellation Policy**

We understand that unanticipated events happen occasionally in everyone’s life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patient’s and out of consideration for our practitioners’’ time, we have adopted the following policies:

* **24 hour advance notice is required** when canceling an appointment. This allows the opportunity for someone else to avail themselves of our services.
* IF you are unable to give us 24 hours advance notice and you are unable to come or fill your time slot with a friend or family member, **you will be charged a cancellation fee of $75.00.**

**Late Arrival Policy**

We try very hard to minimize your waiting time, and in order to do so we need to start and finish appointments on time. Depending upon how late you arrive, your practitioner will determine if there is enough time remaining to start treatment… and regardless of the length o the treatment actually given, you will be responsible for the “full” session.

Out of respect and consideration to your practitioner and other patients, please plan accordingly and be on time.

Patient’s Printed Name

Patient or Guardian’s Signature

Date