Palmetto Metabolic Telehealth LLC

Consent for Treatment • Disclosure • Payment Agreementt

Patient Name: _____

Date of Birth: _____

Today's Date: _____

1. Consent for Treatment

I voluntarily consent to evaluation, consultation, and treatment by the healthcare providers at **Palmetto Metabolic Telehealth LLC**. This may include medical history review, physical/telehealth examination, lab testing,prescription of medications, and other health services related to weight management and/or primary care.

I understand that:

• Treatment is provided via **telehealth** unless otherwise arranged.
• I have the right to ask questions, decline treatment, or withdraw consent at any time.
• No guarantee has been made regarding the outcome of treatment.
• If emergency care is required, I should call **911** or go to the nearest emergency department.

2. Telehealth Disclosure

By agreeing to telehealth services, I acknowledge and understand that:

• Telehealth involves electronic communication (video, audio, messaging, or phone).
• Limitations exist compared to in-person evaluation (such as inability to perform a hands-on exam).
• Confidentiality will be maintained, but no electronic system can be guaranteed 100% secure.
• I must be physically located in a state where the provider is licensed at the time of each visit.

3. Financial Policy & Payment Agreement

• **Palmetto Metabolic Telehealth LLC does not accept insurance, Medicare, or Medicaid.**
• All services are **self-pay** and payment is due at the time of service.
• I agree to pay the published rates for visits, procedures, and any optional add-ons.
• No refunds are provided once services are rendered.
• I am responsible for charges related to lab work, imaging, or medications, which may be billed separately by third parties.
• I will not submit claims to insurance for reimbursement.

4. Privacy & Medical Records

• My medical information will be maintained in accordance with HIPAA privacy rules.
• I may request copies of my medical records in writing.
• Records will not be released without my written consent, except as required by law.

5. Patient Acknowledgement

By signing below, I confirm that I have read, understood, and agree to the above terms regarding treatment, disclosure, and payment. I understand this consent remains in effect until revoked in writing.

Patient/Guardian Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____