Patient Name: _____

Date of Birth:_____

Wellness Clinic Consent

1. Consent for Services

I, the undersigned, authorize the providers and staff of Beyond Urgent Health PLLC to provide care, treatments, and wellness services, which may include but are not limited to consultations, examinations, diagnostic testing, and therapeutic treatments. I understand that the treatments provided are based on evidence-based practices but may not be a substitute for traditional medical care unless otherwise stated.

2. Nature of Services

I acknowledge that the services provided at this wellness clinic may include general wellness treatments, preventive care, and other interventions, such as weight management, IV therapy, nutritional counseling, hormonal therapies, peptide therapies, or other services. I understand that these treatments are aimed at improving overall health and well-being and are not covered by insurance.

3. Risks and Benefits

I understand that:

a. The potential risks, benefits, and alternatives to treatments will be explained to me prior to any procedure or treatment.
b. Results may vary, and no specific outcomes are guaranteed.
c. I have the right to ask questions and request further information before proceeding with any treatment.

4. Financial Responsibility

I understand that I am responsible for the costs of services provided by the clinic. Payment for services is due at the time of the visit unless prior arrangements have been made. I acknowledge that the clinic does not guarantee insurance coverage or reimbursement for services provided.

5. Confidentiality and Privacy

I acknowledge that the clinic follows all applicable laws and regulations to protect my health information. I understand my rights under the Health Insurance Portability and Accountability Act (HIPAA) and consent to the use of my information for treatment, billing, and healthcare operations.

6. Voluntary Participation

I confirm that I am voluntarily seeking care and treatment at Beyond Urgent Health PLLC. I understand I have the right to refuse or discontinue any service or treatment at any time.

7. Acknowledgment and Agreement

I have had the opportunity to ask questions about the services offered by Beyond Urgent Health. I understand the information provided to me and give my consent to receive treatment as outlined above.

Signatures

Patient Signature: _____ Date: _____

Clinic Representative Signature: _____