The Lighter Weigh, LLC

1 Hospital Drive SW, Suite 300
Huntsville, AL 35801
Phone: 256-429-9152 Fax: 256-429-9109

Practice Policies and Consent

We are dedicated to providing the best possible care for you, and we want you to completely understand our practice policies.

1. **Payment is due at the time of service**. **We accept, Cash, all major credit cards**. **If you are not able to pay at the time of your visit, we will ask that you reschedule your appointment until you are able to do so.**
2. There is a fee for forms to be completed by your provider. Forms may take up to 10 days to complete.
3. Our practice requires a fee for medical records requests. Payment is due prior to the release of any records. Please note that it may take up to 10 business days to process medical record requests.
4. Any patient that is **15 minutes late** for their appointment may be required to reschedule.

Prescription Refill Policy
All prescriptions will be filled at the time of a visit. Any lost or misplaced prescriptions will require a visit in order to be replaced.

No Show Policy
If you cannot keep an appointment, please notify our office at least 24 hours prior to visit. If you no-show, you may jeopardize your ability to schedule further appointments in our office.

Electronic Prescription History Data Access
By signing below I give permission for The Lighter Weigh, LLC to access my pharmacy benefits data electronically. This consent will enable The Lighter Weigh, LLC to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

CONSENT:
I have read and understand the practice's policies. I understand that these policies may be amended by the practice from time to time without notice. My **electronic signature** signifies that I have received the practice's privacy statement, and I hereby agree to be bound by the practice's financial policies. I consent to the performance of examinations, diagnostic procedures and treatments which my physician deems necessary. I also give permission to access my prescription history electronically, take a digital photograph for identification and to be contacted via phone, including text messaging. This consent shall remain in effect until I choose to revoke it in writing.

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Signature of Patient (or responsible party, if patient is a minor).