CMWL Billing Consent Form

This form serves three purposes: (1) It says that I want Center for Medical Weight Loss Physician(s) to treat me; (2) It says that Center for Medical Weight Loss can be paid directly by my health plan for covered services; and **(3) In some instances I may have to pay for my treatment.**

1) Consent for treatment

I, or the person who represents me, consent to have Center for Medical Weight Loss Physician(s) provide the medical care that the doctor or the other health care providers taking care of me say I need. Unless it is an emergency, they will describe this medical care and any significant risks that may be involved in my care.

2) Who will pay for my care

I recognize that Center for Medical Weight Loss may bill my health care plan for the care I receive. I agree that payments from my health care plan will go directly to Center for Medical Weight Loss.

I know that under Maryland law, Center for Medical Weight Loss can collect payment from me directly in any of these cases:

a. When I elect to have care that my health care plan covers, but I do not get a needed referral or authorization at the time of service.

b. When I choose not to use my health care plan and agree to pay for care myself.

c. When my health care plan does not include Center for Medical Weight Loss for the care I want, and I agree to pay for care myself.

d. When I receive care that is not covered under my health plan.

I know and understand that I must pay for any co-payment or other part of the bill (i.e. unmet deductible) that my health care plan says I must pay. I know and understand that I may need to pay this before I am treated.

My Signature: _____ Date: _____

For health care agent / guardian / surrogate / parent (circle one), I _____, am the representative for the patient as circled above.

Representative's signature: _____

Address: _____ Phone #: _____

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