Acknowledgement of Financial Responsibility

All professional services rendered are charged to the patient and due prior to service. I have requested medical services from Dr. David Powell and affiliated staff at Elevate Wellness Clinic, LLC and I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that Elevate Wellness Clinic does not accept insurance and that fees are due and payable prior to services rendered and I personally agree to pay all such charges in full. I have requested these medical services and take full financial responsibility for all treatments prescribed for me by Elevate Wellness Clinic and its staff. I understand that there are no returns and all transactions are final. In addition to agreeing to ensure a payment for any treatments, I agree that I will not cancel any credit card payment to Elevate Wellness Clinic, or any of its affiliates for the services I have requested. I agree to pay Monthly Service Fees for testosterone replacement therapy as agreed upon based on the term of my enrollment and any applicable discounts .

Patient / Responsible Party Signature: _____ Date:_____

Printed Name of Patient: _____

Name as it Appears on Card: _____

Billing Address: _____

Credit Card Type and Number: _____

Expiration Date: _____ CSV:_____