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NEW PATIENT HEALTH HISTORY

The information below is confidential and cannot be released without your written authorization.

Thank you for helping us get to know you.

Name: _____

Date of Birth: _____ Today's date: _____

CHIEF HEALTH CONCERN/SYMPTOMS:

_____

_____

_____

_____

MEDICATIONS:

MEDICINE	DOSE	FREQUENCY	MEDICINE	DOSE	FREQUENCY

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MEDICATION ALLERGIES:

_____

_____

HEALTH HISTORY:

Have you ever been diagnosed as having the following?

_____ DIABETES _____ HEART DISEASE _____ HYPERTENSION

PRIMARY CARE PHYSICIAN:

_____

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Recurring ACH Payment Authorization

Patient authorizes regularly scheduled charges to Patient's checking/savings account. Patient will be charged the amount indicated below each billing period. The charge will appear on your bank statement as an "ACH debit". Patient agrees that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us.

I, _____, authorize BetterWeightLoss/James V. Bonds M.D. to charge my bank account indicated below for the amount of the Semaglutide pricing list on the day I received my injection.

BILLING INFORMATION

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

BANK INFORMATION

Account Type: Checking Savings

Account Name: _____

Bank/Credit Union Name: _____

ABA/Routing Number: _____ Acct #: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify BetterWeightLoss/James V. Bonds M.D. in writing of any changes in my account information or termination of this authorization. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that BetterWeightLoss/James V. Bonds M.D. may at its discretion

attempt to process the charge again within 30 days. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of the bank account and will not dispute these transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

_____ _____

Account Holder's Signature Date

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Recurring Credit Card Payment Authorization

Patient authorizes charges to Patient's credit card. Patient will be charged the amount indicated below on the day your injection is given to you. The charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Better Weight Loss/James V. Bonds M.D. to charge my Credit Card indicated below for the amount on the Semaglutide pricing list.

BILLING INFORMATION

Billing Address _____

City _____ State _____ Zip _____

Phone: _____

Email _____

Card Details Visa MasterCard

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ /____ CVV ____ Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify BetterWeightLoss/James V. Bonds M.D. in writing of any changes in my account information or termination of this authorization. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these transactions; so long as the transactions correspond to the terms indicated in this authorization form.

_____ _____

Accountholder Signature Date