**Ladder to the Stars Wellness, LLC**
**22 N Tarragona S, Suite 5**
**Pensacola, FL 32502**

**FEE FOR SERVICE**

**MEDICAL AGREEMENT**

Print Patient Name_______________________________ Date of Birth___________

Street Address____________________________________________________________

City, State, Zip___________________________________________________________

Cell Phone________________________Email__________________________________

I Agree to Text and email Communication:

- ☐ Yes
- ☐ No

Patient or Guardian: _________________________ Relationship to Patient: ____________

1. Medical Consent: I consent to any medical treatments or procedures which may be performed on an outpatient basis (excluding emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of **Ladder to the Stars Wellness, LLC** assisting my care.

2. Financial Obligation: I understand that all Fee For Service (FFS) charges are due at the time of service. I agree to pay **Ladder to the Stars Wellness, LLC** for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. The Fee For Service charges are as follows:

| Service | Fee |
| --- | --- |
| Breastfeeding Initial Assessment (In-Office) | $200 |
| Breastfeeding Initial Assessment (Home Visit) | $250 |
| Breastfeeding Follow Up/Troubleshooting | $100 |
| Annual Wellness | $225 |
| Acute/Sick/One-Time Visit | $125 |
| Follow Up (from One-Time Visit) | $90 |
| Preconception Counseling | $200 |
| Adolescent Sports Physical | $100 |
| 1 Hour In-Depth Problem-Based | $175 |
| 30 Min In-Depth Problem-Based Follow Up | $100 |

3. Acceptable forms of payment include Cash, Credit Card, Debit card. I agree to pay for my visit in full at the time of service.

4. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we will not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

5. Release of Medical Information: I hereby authorize **Ladder to the Stars Wellness, LLC** to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.

6. The undersigned certifies that he/she has read and agrees to the above and foregoing, and received a copy thereof, and is duly authorized to enter this FFS agreement.

Patient or Guardian Signatures: ________________________________Date: ___________

**AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION**

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Payments are made directly through our secure link accessed through your electronic statement sent to your email.

**Customer(s)Name(s)**:_______________________________________________________

**PAYMENT INFORMATION**

I authorize **Ladder to the Stars Wellness, LLC** to automatically bill the card listed below as specified: Amount: $__________ for Fee for Service;

Billing on: ____/____/____

**CREDIT/DEBIT CARD INFORMATION:**

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

| ____________________ | _____/_____ | __________ |
|---|---|---|
| Credit card number | Expires | CVC (Security Code) |

________________________________________________________

Cardholder's name: As shown on credit card

__________________________________________________

Customer's signature Date

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_________________________________________________

DATE

__________________________________________________

SIGNATURE