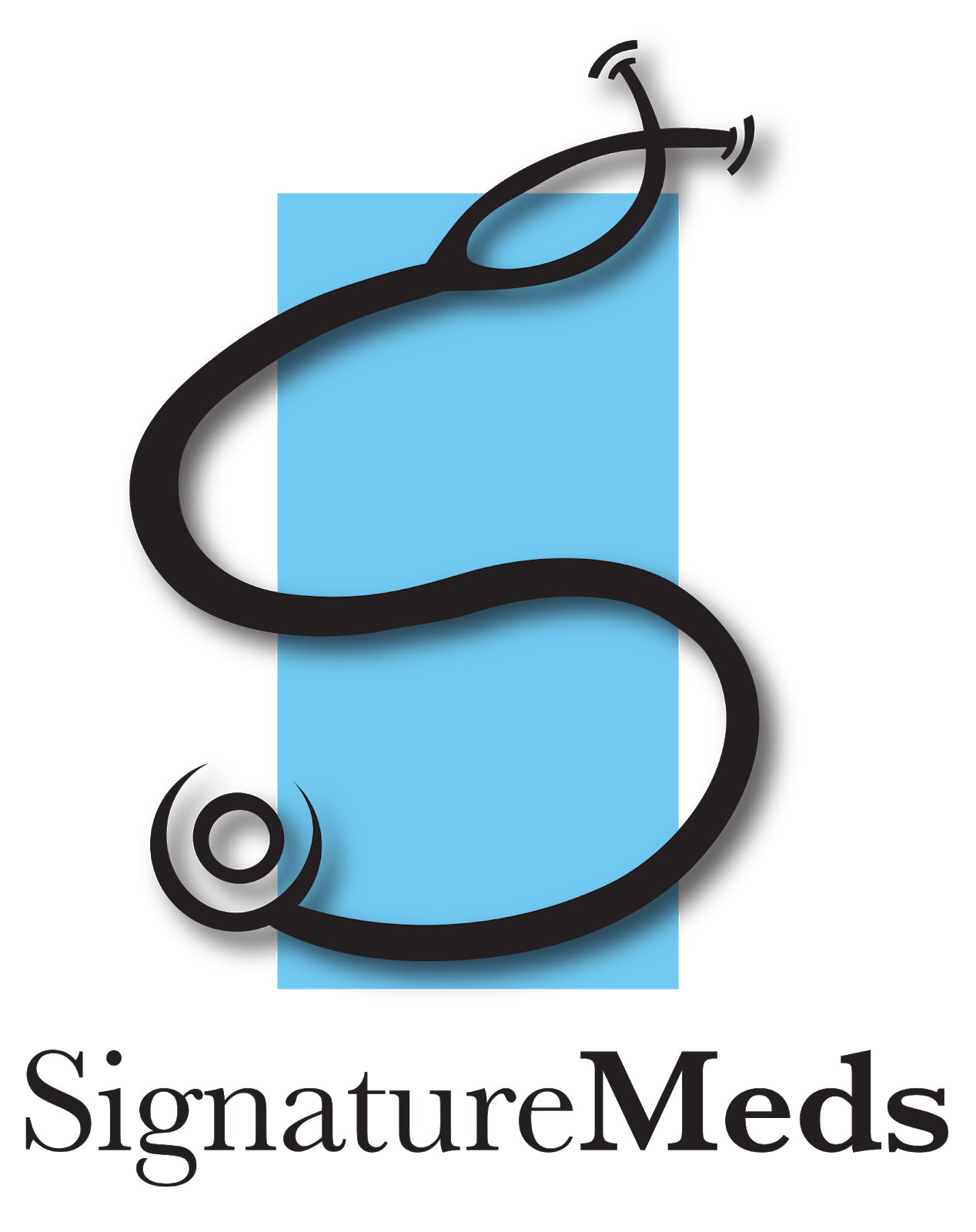
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**Mohamed Shahed, M.D.**

19050 Lorain Road

Fairview Park, Ohio 44126

Phone: 216-252-8000 **|** Fax: 216-252-8117

Email: signaturemedsstaff@gmail.com

THANK YOU for selecting Signature Meds, LLC as your primary care office. To facilitate your treatment here we ask that you read and sign this agreement and authorization.

If you have any questions about the following guidelines, please do not hesitate to ask for clarification.

* A scheduled appointment must be cancelled at least 24 hours in advance; otherwise, a $30 cancellation fee will be assessed. A complete no-call no-show will result in a $50 fee. If there is an excess of 3 no-shows or no advanced cancellations, this will result in a discharge from the practice.
* Amounts that are associated with your services co-payment(s), past balance(s) and fees assessed must be paid prior to next treatment or a payment plan has been arranged.
* We will bill your insurance carrier as a convenience to you however, if your carrier reimburses you, you agree to inform us of the receipt and pay us promptly.
* If your care is not covered by insurance, you agree to be responsible for payment of all fees in full.
* You agree to complete health maintenance type blood work and scan(s) to better assist you in providing the most up-to-date health care.
* Regarding weight loss treatment(s)/care, I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_will keep all my scheduled appointments and understand if I am not compliant with all the referenced items above, I forfeit my care plan.

I hereby authorize and request Signature Meds, LLC to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in the judgment of the Mohamed Shahed, MD that are deemed necessary and advisable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINT PATIENT NAME