CONDITIONS OF TREATMENT AND FINANCIAL AGREEMENT (FEE-FOR-SERVICE)

I hereby consent to and authorize the giving of all treatments which, in the judgment of the attending physician, may be considered necessary or advisable for my diagnosis or treatment.

I understand that I am fully and personally responsible for payment of the doctor's charges. Failure to comply with this policy may result in postponement or cancellation of future visits.

If for any reason an appointment must be cancelled by the patient, 2 full working days' notification will be given to the physician's office (two working days, weekend days and holidays do not count). Failure to properly notify the physician will result in charges at the usual rate for that appointment. Such charges are not reimbursed by insurance programs.

I understand that the doctor may charge for telephone consultations, e-mail, texting, and for all other uses of his time on my behalf.

I have read and understand the above agreement and will abide by these policies.

_____ _____

PATIENT **SIGNATURE/DATE**

_____

PATIENT'S GUARDIAN (if applicable)

10850 WILSHIRE BOULEVARD, STE 1260, LOS ANGELES, CA 90024 PHONE: +1 (310) 818-3821
EMAIL: DRWEXLER@DAVIDWEXLERMD.COM WEBSITE: WWW.DAVIDWEXLERMD.COM