



## WEIGHT LOSS PROGRAM AGREEMENT

This document outlines the terms and conditions of the Prestige Regenerative Medicine (PRM) Semaglutide Weight Loss Program, referred to hereinafter as "Program."

### **INCLUSIONS:**

**Medication:** This Program includes the monthly prescription of Compounded Semaglutide/Vitamin B12 – this is a proven, safe, effective way to decrease appetite. It is started at a very low dose and is increased monthly until the maximum recommended dose is reached and sustained. Dosage will be determined by PRM Providers and can be adjusted based on patient's reported side effects.

**Supplemental Injections:** The Program also includes the weekly administration of Methionine/Inositol/Choline (MIC) injections, or an alternative fat burning supplement. This is a combination of amino acids and vitamins that has been shown to have a lipotropic effect. Please be sure to schedule your injections weekly at PRM- they should take only a few minutes. These injections are entirely optional and not mandatory for participation in the program.

**Lab work:** At the conclusion of 24 weeks and 52 weeks of the weight loss program, lab work will be prescribed by our medical team through our lab partner, Quest Diagnostics. The cost of this lab work is covered by the Program and will evaluate the impact of the Program on your overall health.

**Medical Oversight:** This Program also includes a brief consultation every 4 weeks with a Prestige Regenerative Medicine provider for evaluation of side effects, revision of treatment, and other medical questions. Completion of these consultations is optional, but highly recommended to ensure optimal treatment and to note any health history changes. Please be sure to schedule these consultations.

**Integrative Nutrition Coaching:** This Program also includes an Introductory Consult with a certified Nutritionist, which will occur at the beginning of your treatment to help implement lifestyle changes to ensure optimal success. The Program includes two 30-minute follow-up consults with our Nutritionist for continued coaching. If patients would like to schedule additional time with the Nutritionist, this is charged according to the PRM standard fee schedule.

### **FEES AND PROGRAM TERM:**

The fee for this Program is \$500.00 per four (4) weeks. The Program has a 24-week minimum term, as this is the minimum amount of time needed to properly administer treatment, though most patients see maximum weight loss benefits after completing at least 52 weeks of treatment. After the initial 24-week term, the Program will continue until the patient provides a 30-day notice by phone or in writing of the desire to cancel. Medications are ordered automatically, and patients do not need to request refills. Due to the length of time required to ship the medication from our compounding pharmacy, this 30-day cancellation notice is essential for our staff to ensure that the medication order is cancelled in a timely fashion.

### **PAYMENT OPTIONS:**

Three payment options are available.

**Option 1:** Monthly subscription plan – PRM will set up automatic electronic payments. The initial \$500.00 payment is required in full to order the first 4 weeks of medication, and then patient's account will be charged recurring payments of \$125.00 per week.

**Option 2:** Patients who prepay for the 24-week Program receive a discount of 5%, for a total price of \$2850.00 for the initial 24-week term. At the conclusion of the initial 24-week term, the Program will continue and automatic electronic monthly payments of \$125.00 per week will begin until notice is given to cancel.

**Option 3:** Patients who prepay for the 52-week Program receive a discount of 10%, for a total price of \$5850.00 for the 52-week term. At the conclusion of the initial 52-week term, the Program will continue and automatic electronic monthly payments of \$125.00 per week will begin until notice is given to cancel.



**WEIGHT LOSS PROGRAM AGREEMENT**

**PATIENT ALSO AGREES TO THE FOLLOWING:**

I consent to receive emails and/or text messages regarding my payment activity at the email address and/or mobile phone number previously provided to PRM. I agree to pay according to the selected payment option and I hereby attest that I am the owner of the bank account(s) or credit/debit card(s) referenced in my account. I understand that should a default occur, I will be obligated to pay my provider for additional charges incurred by my provider related to the costs of collection, including but not limited to collection agency fees, court costs, and attorney fees.

I, (patient name) \_\_\_\_\_ select the following payment option:

Option 1: \$500.00 per 4 weeks, charged initially as \$500 for the first 4 weeks of medication, and then auto charged as \$125 per week starting on (date) \_\_\_\_\_. I understand that I am committing to a 24-week minimum term.

Option 2: 24-Week Prepayment Discount Program – A payment of \$2850.00 will be collected today. My card information will be saved to continue treatment after the initial 24-week term is completed, and the \$125.00 per week auto charge will begin on (date) \_\_\_\_\_.

Option 3: 52-Week Prepayment Discount Program – A payment of \$5850.00 will be collected today. My card information will be saved to continue treatment after the initial 52-week term is completed, and the \$125.00 per week auto charge will begin on (date) \_\_\_\_\_.

If I wish to cancel this agreement after the minimum 24-week term has been completed, I must provide at least a 30-day notice by phone or in writing.

**My signature indicates that I agree with the terms and conditions herein.**

**Printed Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**PRM Staff Signature:** \_\_\_\_\_