<u>RETURN & REFUND POLICY</u>

[clinic name] is a medical clinic providing the latest safe and effective treatments for weight loss. **[clinic name]** is a cash clinic that does not accept medical insurance. We provide full paperwork for patients to seek reimbursement for any services and prescription medications that may be covered by the patient's insurance. Payment for services is the responsibility of the patient regardless of insurance coverage. This return policy constitutes the only conditions applying to the return of products and services, no other policy to this effect exists, and this policy supersedes all prior policies.

GENERAL

1. **[clinic name]** does not offer refunds on accounts with outstanding claims or balances; or where upcoming services are scheduled.
2. **[clinic name]** does not allow the transfer of services or treatments to other individuals or other clinics.
3. Submission of the returned product does not constitute acceptance of the return **[clinic name]** reserves the sole right to determine whether the products or services qualify for replacement/refund. **[clinic name]** also reserves the sole right to refuse a return as it deems appropriate.
4. Refunds less than $25.00 will not be processed.

ITEMS DEEMED RETURNABLE

[clinic name] will not issue a refund, but will promptly replace items meeting the following criteria:

1. Recalled products.
2. Incorrect shipments
3. Damaged product due to shipping carrier

ITEMS DEEMED NON-RETURNABLE

[Clinic name] does not accept the return or refund of:

1. Services provided or performed; including but not limited to physician visits and patient training. If initial patient training was unsuccessful. **[clinic name]** will additional trainings at no cost to the patient, as needed.
2. Products or services not purchased directly from **[clinic name]; [clinic name]** reserves the right to destroy non- **[clinic name]** products shipped as a returned product and to charge the patient for the cost incurred to process and destroy the non- **[clinic name]** product.
3. Prescription medications, including but not limited to any prescription written by a licensed physician.
4. Damaged products, including but not limited to missing or damaged labels, repackaged product, opened product, and product otherwise not in its original form.
5. Mishandled products, due to patient's improper handling or storage of the products.

PROCESS FOR RETURNS/REFUNDS

[clinic name] will only accept the return of product for consideration of refund, if applicable, under the following conditions:

1. For recalled products:
    a. In the event of a recall initiated **[clinic name]** or any other pharmacies used **[clinic name]** or government agency, **[clinic name]** agrees to pay reasonable out-of-pocket costs for costs incurred by the patient.
    b. California Medical Group will provide the patient with instructions on how to return any recalled product.
2. For incorrect shipments, and products damaged due to shipping carrier:
    a. **[clinic name]** must be notified within seven (7) days of the incorrect of damaged shipment. Please contact the office at **[clinic phone#]**
    b. Mail the product via USPS to **[clinic address]**
    c. Damaged products will be replaced, not refunded, within seven (7) business days after receipt of an approved return.

CANCELLATION OF FUTURE PURCHASES

If the patient chooses to discontinue participation in the monthly subscription service to receive medication, the patient must inform **[clinic name]** in writing, at least 30 days prior to the charge date for the next shipment. Failure to do so will result in the charge being completed, and no refund will be issued.

CHARGEBACKS INITIATED BY THE PATIENT

[clinic name] takes patient care very seriously, and our clinics strive to provide the highest quality care to every individual. In the event the patient is not satisfied, we ask to please. refer to this document rather than initiating a chargeback with one's credit card company. If a chargeback is initiated **[clinic name]** will use all documentation available to refute the chargeback including patient acknowledgment of the refund policy.

By Signing below, I am agreeing that I have read, understood, and agree to the items contained on this document.

Signature: ____

Print Name: ____

Date: __________________________

[clinic name] Representative: ____

[clinic name]
[clinic address]
[city, state, zip code]
[phone #]