Stop the Weight Struggle Program

Financial and Scheduling Policy

The "Stop the Weight Struggle" program includes the following:

- One, initial 60-minute appointment to review blood results, discuss continuous glucose monitoring device and medication and the initial dosage level of Ozempic.

- Six follow up visits (in person or virtual) of 30 minutes duration each for the purpose of monitoring the patient's progress and safety, and to re-evaluate the correct dosage level.

- All 7 appointments (one (1) 60-minute appointment and six (6) 30-minute follow up appointments) must be used within the 12-month period from date first appointment.

- Appointments are designed purely for the purpose of addressing the "Stop the Weight Struggle" program and are not designed to review other health conditions or extended lab results. Any other health conditions, lab results or other health issues (such as hormone replacement therapy) need to be addressed in a separate appointment.

- If you are not an established patient of Aidun Medical, LLC, and would like to discuss health issues **unrelated** to the "Stop the Weight Struggle" program, a new patient appointment must first be scheduled so that we can evaluate your other conditions and establish the correct follow up protocol for those other issues.

- As always, the cost of medication, blood work and any possible supplementation is not included in this or any other program.

Refund & Cancellation Policy

If, within 2 weeks of your first "Stop the Weight Struggle" appointment (in person or virtual) with Aidun Medical, LLC, you decide to discontinue the program, you will be refunded as follows:

Established Patients

Established patients will be refunded the program fee, less an initial appointment fee $350.

New Patients

New patients will be refunded the program fee, less the new patient appointment fee of $_____.

No refunds will be granted after 2 weeks from date of first appointment for any patients.

No medical treatment plan is 100% guaranteed.

Please indicate your understanding and acceptance of these financial and scheduling policies by signing below.

Patient's name _____ Date_____

Patient, guardian, or guarantor signature

_____ Date_____

Witness_____ Date_____