The LifeStyle Clinic
Healthcare for Your Life, Your Style

PATIENT ENGAGEMENT AGREEMENT

FOR JOSEPH C. LEE, DO & THE LIFESTYLE CLINIC

In consideration of receiving medical treatment and advice, receiving prescriptions with instructions, as well as any information provided to me from JOSEPH C LEE, DO (THE DOCTOR) AND/OR THE LIFESTYLE CLINIC (THE CLINIC) AND/OR ANY AGENTS OR CONTRACTORS THEREOF, I (THE PATIENT) hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge JOSEPH C LEE, DO AND THE LIFESTYLE CLINIC located at 4127 NW 122nd Street, Suite E, Oklahoma City, OK, his practitioners, affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any injuries or problems that may arise from advice, medications or treatment.

I AM VOLUNTARILY PARTICIPATING IN EVALUATION, TREATMENT, AND THIS DOCTOR-PATIENT RELATIONSHIP ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH RECEIVING MEDICATIONS, ADVICE AND TREATMENT. I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, BY MY ENTERING INTO THIS AGREEMENT.

I agree to indemnify and hold harmless against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If THE DOCTOR incurs any of these types of expenses, I agree to reimburse JOSEPH C. LEE, DO & THE LIFESTYLE CLINIC. I acknowledge that JOSEPH C. LEE, DO, THE LIFESTYLE CLINIC and all representatives and agents of such are not responsible for errors, omissions, acts or failures to act of any party or entity on behalf of THE DOCTOR OR CLINIC.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of JOSEPH C. LEE, DO & THE LIFESTYLE CLINIC including agents and employees.

In the event that I should require other medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I decline a printed HIPAA form or handout and I am instead referred to: https://www.hhs.gov/hipaa. I understand that if I request, I will be provided with a copy of the same and this agreement. I understand that my Health Protected Information will remain confidential to the best of the clinic's and physician's efforts. I understand that the physician, practitioner, clinic or any of its associates may from time to time send electronic communications to expedite my care and I hereby consent to have those communications sent via means that may not fall under the category of being "HIPAA Compliant". I understand that the physician, practitioner, clinic and its associates shall always make every effort to keep my information safe.

I agree to be punctual for my appointments and to give 24 hours notice of change. I understand that arriving more than 15 minutes late for an appointment will be considered a "No Show" and I may forfeit my appointment if time does not allow for the provider to see me at that time. If I "No Show" for an appointment, I understand that to secure another appointment I may be required to pay upfront, wholly or partially, for the appointment. I fully understand that this paid fee is non-refundable.

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PRINTED NAME OF PATIENT

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SIGNATURE OF PATIENT

_____

DATE

Opt-in to Electronic Communications YES NO

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EMAIL ADDRESS

Revised 06/05/2020