ACKNOWLEDGEMENT OF OFFICE POLICIES

1. **Missed/Canceled appointments:** A missed appointment or late cancellation fee of $25.00-$50.00 will be accrued for any notice less than 24 hours.

2. **Returned Checks:** There will be a $15.00 fee for all returned or stopped checks after services are rendered.

3. **Insurance Patients:** *AS A COURTESY* we will file your insurance claims for you. Any portion not covered by your insurance plan is your responsibility. We will try to estimate your patient portion as accurately as possible and payment will be due at the time of service. For your convenience, we offer the option to keep your credit or debit card on file to charge your portion **after** your insurance claim has been processed.

4. **Non-Insurance Patients:** On the day of service, we will collect your portion for the services rendered.

I have read, understand, and agree to abide by the above office policies.

Patients Name Printed: _____

Signature of Responsible Party: _____

Relationship to patient: _____

Date: _____

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