



Patient Name: _____

DOB: _____

CANCELLATION / NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to cancel your appointment. A \$10.00 dollar fee will be applied for (No Shows).

When performing lab work at our office you are responsible for payment of a \$10.00 dollar drawing fee, if applicable.

PATIENT FINANCIAL RESPONSIBILITY

We appreciate the confidence you have shown in choosing us to provide with your health care needs. The services you have elected to participate in imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any deductible and co-payment / co-insurance as determined by your contract with your insurance carrier. We expect to receive the payment at time of service. You are responsible for any amounts not covered by your insurance. If your insurance denies any part of your claim, or if you and your physician elect to continue past your approved period, you will be responsible for your balance in full.

I have read and understand the above information, and I agree to the terms describe above.

I authorize my insurer to pay any benefits directly to Comprehensive Health Center, the full and entire amount of the bill incurred by me or the above named patient if applicable any amount due after payment has been made by my insurance is my responsibility.

Patient/ Guarantor Signature

Date