Acupuncture and Chinese Medical Center

Statement of Patient Financial Responsibility

Patient Name: _____Date_____

Package Purchase Policy

In an effort to help decrease costs, we offer a package at a discount rate. The package is non-refundable but has no expiration date and may be shared with family and friends should I choose to purchase the package.

I have read and understand the above Package Purchase Policy, and I agree to the terms described. Initials_____

Cancellation / No Show Policy

We kindly ask that you let us know 24 hours in advance if you are unable to keep your appointment. Our fees are very reasonable for the care you deserve and desire. No-shows will be charged $20. Same day cancellations will be charged $10. Since you scheduled an appointment, we have to reserve a treatment room exclusively just for you which means patient who is waiting for an appointment is unable to get in.

I have read and understand the above Cancellation / No Show Policy, and I agree to the terms described. Initials_____

Returned Check Policy

A $40.00 charge applies to returned checks.

I have read and understand the above Returned Check Policy, and I agree to the terms described.

Initials_____

I have read and agreed the above polices regarding my financial responsibilities to the practitioners in Acupuncture and Chinese Medical Center for the above named patient.

Patient/Guarantor Signature _____Date_____