Insurance Information

Patient Name: ____________________________________ DOB: ___________________

Subscriber Name: __________________________________ DOB: ___________________

Subscriber SSN: ____________________________________

Insurance Name: ___________________________________

Employer Name____________________________________

I hereby agree to pay all charges that exceed or that are not covered by insurance.

________________________________ __________________________
Patient/Parent Signature Date

Cancellation Policy

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. However, we require patients to reschedule or cancel appointments within 24 hours of a scheduled visit.

If you no show or fail to reschedule/cancel an appointment without giving the 24 hours notice a $50 charge will be applied to account. The patient cannot be rescheduled until this fee is paid.

Patient Name: ____

Patient/Parent signature: _________________________________ Date: ________________