**Patient Payment Agreement & Cancellation Policy**

Please carefully read the following agreement. It explains your financial obligations while under our care and our policies. Payment is always due at the time of service. We accept the following forms of payment:

* Currency
* Check
* Visa
* MasterCard
* Discover
* AmEx

**CANCEL POLICY**

If you cancel your appointment with less than 48 hours’ notice, or fail to show for your appointment without notification, your credit card will be charged $70.

If you call to cancel your appointment with less than 48 hours’ notice and choose to reschedule another appointment at that time, you will be charged the standard normal deposit of $70.

If you reschedule your appointment and then cancel with less than 48 hours’ notice, or fail to show for your appointment without notification, your credit card will be charged for the full price of the visit.

**RETURNED REFUND POLICY**

There is a $35.00 fee for a returned check. After two (2) returned checks for non-payment, cash will be required for all future appointments.

**REFUND POLICY**

There is no refund on services or purchases rendered. Gift certificates are Not-Refundable, Replaceable ore Redeemable for cash. Medications are non-transferrable.

Copies of our labs are provided once, at the time of your visit/ follow up appt per request at no charge.

Copies can be sent to your primary care physician only, at no charge.

**APPOINTMENT POLICY**

Initial comprehensive appointment fee is due at the time of the visit.

Second consultation appointment is required for review of clinical findings and treatment plan.

You have the option of paying for both visits on the initial visit at a reduced price.

After 2 phone calls or 2 emails regarding a medical concern, a visit or phone consultation is required.

**A $100 deposit is required to secure your appointment.**

**A $50 deposit is required for all Micronutrient IV appointments.**

By agreeing to and/or signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission for us to charge your credit card if any of the above stipulations apply to you.

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Print Patient or Guardian Name

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Signature Date