Patient Contact Information

Please provide us with the following information so we will be able to contact you about your appointments.

Name:_____

Home phone:_____

Cell phone_____

Work:_____

E-mail:_____

What is the best time and place to reach you?_____

_____

What days and times are best for you to schedule appointments? _____

_____

We reserve the right to charge a collection fee (25%-40%) to your account and turn it over to an outside collections agency if the balance remains unpaid for more than 60 days. We will gladly file your insurance for you as a courtesy. It is your responsibility to make sure that your account remains in good standing and that your insurance portion is paid.

We reserve time in our schedule especially for you. Although we do not anticipate that any of our patients would miss an appointment, we reserve the right to charge for appointments cancelled or broken without 24 hours notice. **There will be a $50.00 charge to your account if you fail to make your appointment or if you cancel your appointment without 24-hours notice.** Patients who fail to make their appointment or cancel without notice 4 times in one year will be released from the practice.

Sign_____ Date_____