Clinic Policies

PLEASE READ CAREFULLY BEFORE INITIALING & SIGNING

Please **initial** that you understand and agree to the following statements:

Payment Agreement

Payment for all services, tests, and medicinary items (that are not covered by your insurance) are due at the time of service. Returned checks will be subject to a **$50.00 NSF fee**. **Initial: _____**

Product Returns

We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. We **cannot** accept returns on any medicinary products. **Initial: _____**

Cancellations and Missed Appointments for new and established patients

We understand that there are times when things come up. However, failing to call and reschedule, or cancel, your appointment denies other clients the ability to book their own appointment. **Initial: _____**

IV Therapy Appointments/10 Pass Ozone: Cancellations with less than a 24-hour notice will be charged a 75% fee of the service that you were scheduled for. No-shows will be charged 100% of the service that you are scheduled for. **Initial: _____**

Appointments with Dr. Kapoor: A No Show or missed appointment, without the proper 24-hour notification will be assessed a $75.00 fee. This fee is not billable to your insurance. **Initial: _____**

Late Arrivals: We understand that delays may occur and our goal is to keep our services running on time. Should you arrive more than ten minutes past your scheduled appointment time, we may not be able to serve you. (We will try our best to accommodate you) If we are unable to reschedule you, a late cancellation fee may apply. **Initial: _____**

Dr. Kapoor accepts several **insurance** plans and will bill both primary and secondary insurance plans as a courtesy. However, primary **responsibility for the account is yours.** Some insurance plans have restrictions or a specific provider panel that patients must access. **Please check with your insurance carrier** for specific eligibility, benefits, provider panel and/or referral requirements as they apply to you. **Initial: _____**

I have read and understand the above-stated policies and will comply with those I have initialed in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Signature:

Date