Shannon Considine, L.Ac., M.Ac.

Patient Financial Agreement

I acknowledge that I am the financially responsible party for payment of any Service, Treatment, Referral or Cancellation fees incurred by

_____

Patient's Full Name (PRINTED)

and provided by Shannon Considine, Acupuncture Therapist, and staff if:

1) **the services provided are not covered by Patient's insurance;**
2) **the insurance information provided by the Patient is not accurate;**
3) **Patient is now or becomes uninsured.**

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Self-Payment and insurance co-pay and deductible fees are due at time of service.

Returned check fee $25 - for any checks returned by your bank.

Cancellation Policy – 24-hour notice required.
Appointments cancelled within 24 hours of scheduled appointment time are subject to a $40 cancellation fee payable directly by patient.

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Printed Name & Address of Financially Responsible Party

_____ _____ _____

Responsible Party Signature | Relationship to Patient Self or Other (Please Describe) | Today's Date