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Walnut Creek Office:

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www.walnutcreekskinandlaser.com

Financial Policy Acknowledgment Print Patient's Name _____ Date of Birth: ____/___ **Payment Obligations** I hereby assign, Walnut Creek Skin and Laser all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service included co-pays, deductibles, non covered services or administrative fees (e.g. late cancel, no show, return checks, collections fees). I also understand that if I do not fulfill my payment obligation to Walnut Creek Skin and Laser, my account will be subject to a full collection process. Any expenses related to the cost of collection and/or legal will be my responsibility. I acknowledge I have read and I have copy of the practice's Financial Policy (document 2450). There is a copy posted on the website www.walnutcreekskinandlaser.com Fees for No Show Visits or Late Cancellations: Cancellation of office visit less than 24 hours business day prior to the appointment \$25.00 Cancellation of surgical procedure less that 24 hour business day prior to the appointment \$100.00 Administrative Fee (for past due account over 90 days sent to Collection) \$25.00 No Show for scheduled office visits \$40.00 \$150.00 No Show for a scheduled surgical procedure Returned Checks (amount added to amount of check) \$25.00 Patient's Signature _____ Date____

Staff's Signature _____ Date ____