



PATIENT REGISTRATION & FINANCIAL AGREEMENT

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

Date of Birth _____

Emergency Contact _____ Relationship _____ Phone _____

I consent to treatment and care under the general and specific instructions of Dr. Sandra Kamiak, her assistant and/or her designees as is deemed necessary.

Patient's Signature _____ Date _____

Parent or Responsible Party _____ Date _____

FINANCIAL RESPONSIBILITY AGREEMENT

As a service agreement, Dr. Sandra Kamiak requires all patients to acknowledge and sign this form. Please initial, this indicates that you have read and fully understand the terms of this agreement.

_____ I understand, I am fully responsible for the fees and charges for my medical services provided by Dr. Kamiak. Your appointment is a special time we are holding for you.

_____ I understand, a \$20.00 administrative fee will be charged for returned checks. This is in addition to the session fees.

_____ I understand, it is my responsibility to inform the office of any change in address, employment and contact information

_____ I understand and agree to the following fee schedule for changes and cancellation made inside of the allotted cancel/change time frames:

New patients:

Cancellations/Changes must be made 24 (twenty-four) hours in advance. **I understand**, any missed appointment or cancellation, made without at least 24 hours notice, will result in a full session charge of \$375.00 for the initial one and half hour- two hour visit. Or \$250.00 fee, if we only scheduled an initial hour.

Returning Patients:

I understand, Cancellations/Changes must be made at least 24 (twenty-four) hours in advance of the scheduled appointment or a fee for holding the time will be charged as follows:

25 minute appointment = \$90.00

50 minute appointment = \$180.00

 Signature of Patient or Responsible Party and Date