Sandra Kamiak, M.D.
Classical Homeopathy – Psychosynthesis
(408) 741-1332

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:

For All Patients: Cancellations or changes for appointments must be made at least 24 (twenty-four) hours before the time of the visit. Otherwise, you will be responsible for full payment of that missed appointment.

_____

Signature of Patient or Responsible Party and Date

14583 Big Basin Way-Unit 3B, Saratoga, CA. 95070-6072
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