SOUTH BAY TOTAL HEALTH

Please fill out and return, and keep a copy for your records

version 11-25-2009

Financial Responsibility Statement

- I understand that the services and therapies offered by South Bay Total Health are considered "Alternative" and may not covered by most health insurance companies, including Medicare, Medicaid, and Medi-Cal.
- I understand that South Bay Total Health will not file health insurance claims for me.
- I acknowledge financial responsibility for all charges for services rendered.
- For your convenience we accept cash, personal checks, Visa, Mastercard, American Express. There is a $75 fee for any returned checks.
- Payment is due at the time of service.
- Any items from the medicinary must be paid in full upon receipt. Unfortunately, there can be no refunds for products which have been opened, special order items, or for custom formulations.

- **Cancelled and missed appointment charges:**
  New Patients: Due to the significant time set aside in the doctor's schedule for new patient appointments, a 48 hour business day cancellation is required for all new patient appointments. Weekend days are not included in this. South Bay Total Health does not double book appointment times, so when an appointment is made that time slot has been reserved for you. If you fail to keep this appointment, it prevents others from being treated. All new patient appointments that are cancelled without a 48 hour business day notice will be charged a $200.00 cancellation fee. There are no exceptions.

  Established Patients:
  Any missed appointments, or cancellations with less than a 24 hour business-day notice will incur a charge of $100. There are no exceptions.

  Reasonable emergencies will be forgiven at our discretion.

- Phone Call policy: Patients are welcome to call if you have questions after your office visit. Often, clarifying issues and answering basic questions can greatly enhance the success of your health care. Due to time constraints, however, phone calls longer than 5 minutes regarding existing treatments, or any new conditions will be billed as a phone consultation.

By signing below, I _____ certify that I fully understand the above policies.

Patient Name: _____

Signature: _____ Date: _____

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