

Financial Responsibility and “No show” Policy

1. I Hereby accept financial responsibility including but not limited to all co-payments, coinsurances and payment of all deductibles and out-of-pocket expenses. I understand co-pays are due at time of service, to be paid by cash debit/credit card only.
2. I hereby authorize the payment of health insurance benefits to Comprehensive Care Providers for services rendered. I hereby authorize Comprehensive Care Providers to release any health information necessary to complete and process my insurance claims.
3. I understand that Comprehensive Care Providers may charge a $25 “late cancel” fee in the event that I do not call with at least 24 hours’ notice to cancel an appointment or a $50 “no show” fee for a missed physical appointment. The provider will give a 10-minute grace period before an appointment is canceled as no show, on the day of your appointment.

By signing below, I acknowledge, and I understand and agree to the above notices of financial responsibility and acknowledge that I received a copy of this notice.

Name (print): DOB:

Signature: Date: