


East West Medicine 

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**Appointment and Financial Policy**

Thank you for choosing East West Medicine to enhance your health and well-being. We strive to provide excellent medical care to our patients as well as a delightful experience. Please take a few moments to read over our appointment and financial policy, so that we can ensure the convenience of our patients and staff.

**Appointment Policy**

- \* We understand that emergencies arise and appointments may need to be rescheduled. In the event of an emergency, please call our office as soon as possible.
- \* If you need to cancel an appointment, please provide us with 24 hours notice so that we may have the opportunity to help someone else in need. Failure to do so will result in a fee of \$30 for a missed appointment. We value your time at each visit and will be happy to assist you in rescheduling.
- \* If you expect to be more than 15 minutes late, please call to confirm availability.

**Financial Policy**

The responsibility of the practitioner is to address your health with expertise and comprehensive health care. The responsibility of the patient is to provide payment at the time that services are rendered. Payment is accepted in the form of cash, Visa, Mastercard & American Express.

In the case that patients have insurance coverage, we will provide an electronic invoice to your insurance company to be processed for direct reimbursement to you. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill. It is advised that you ask your insurance company how much they are willing to pay for an out-of-network provider, and receive this information in writing, fax or e-mail.

*I have read and fully understand the appointment and financial policy. Any questions I have concerning my appointments have been answered.*

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Signed

Date

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Printed Name of Patient or Representative

Relationship

*I authorize the provider to release any information required to process any insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or by my insurance company at any time in writing.*

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Signed

Date