



## CLINIC POLICIES

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### **General Policies**

Payment is required at the time of your visit. Returned checks incur a \$25.00 fee, due and payable immediately.

24 hour notice required to cancel an appointment. A 24 hour voicemail system is available and will record your message with a date and time stamp.

Patients who do not call to notify Gotham Wellness Acupuncture PLLC within the required 24 hours will be responsible for the full appointment fee.

If a patient is late, the appointment will be shortened, and will end according to the original end time. Late patients will be charged the full fee regardless of length of visit.

We reserve the right to dismiss patients for inappropriate conduct, non-payment or late payment of fees, medical reasons, safety concerns and other situations as determined by Gotham Wellness Acupuncture PLLC.

### **Acknowledgement of Review of Notice of Clinic Policies**

I have reviewed and understood Gotham Wellness Acupuncture PLLC notice of clinic policies. I understand that paper copies of the Notices are available for my files and I may request a copy at any time

I have reviewed, understood and agree to abide with the office policies stated above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **New York State Requirement**

New York State Law requires that Gotham Wellness Acupuncture LLC encourages you to go to an M.D. for any health problems for which you are seeking treatment. Please sign here to acknowledge that you have read and understand this statement, and please feel free to ask us if you have any questions.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_