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 Capitol Wellness DC LLC 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 Capitol Wellness DC LLC.

Acknowledgement of Review of Notice of Clinic Policies

I have reviewed and understood Capitol Wellness DC LLC 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: ____________

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