



Patient Financial Partnership Agreement

I acknowledge that I am financially responsible for payment of any service, missed appointment, or cancellation fee incurred by _____
PRINT PATIENT'S FULL NAME
provided by WisdomWell practitioners.

A returned check fee is \$25 for any check returned by your bank.

<i>Comprehensive History/Diagnosis (Initial Appointment of 1-2 hours)</i>	\$ 150.00
<i>Acupuncture Treatment</i>	\$ 85.00
<i>Late Cancellation/Missed Appointment</i>	\$ 85.00

The Late Cancellation fee will be applied if an appointment is canceled less than 24 hours before the scheduled appointment. Exceptions will be made in the event of an emergency.

Name and address of financially responsible party: _____

Street City/State Zip

E-mail Phone Number

Responsible Party Signature Relationship to Patient Date