

Shannon Considine,
L.Ac., M.Ac.

Patient Financial Agreement

I acknowledge that I am the financially responsible party for payment of any Service, Treatment, Referral or Cancellation fees incurred by _____

PRINTED Patient Full Name

and provided by Shannon Considine, Acupuncture Therapist and staff if

- 1) the services provided are not covered by Patient's Carefirst Blue Cross Blue Shield insurance
- 2) the Carefirst BC/BS insurance information provided by the Patient is not accurate.
- 3) Patient is now or becomes uninsured through Carefirst BC/BS

*****Self Payment and Carefirst BC/BS co-pay and Carefirst BC/BS deductible fees are due at time of service*****

Returned check fee \$25 - for any checks returned by your bank

Cancellation Policy - 24 hour notice required

Appointments cancelled within 24 hours of scheduled appointment time are subject to \$35 cancellation fee payable directly by patient.

Printed Name & Address of Financially Responsible Party

Responsible Party Signature

Relationship to Patient
self or other (please describe)

Today's Date