NECK, BACK & BEYOND HEALING CENTER

# Patient Financial Partnership Agreement

I acknowledge that I am the financially responsible party for payment of any service, missed appointment or cancellation fees incurred by

_____ ***(print patient name)***

provided by Neck, Back & Beyond Healing Center practitioners.

There is a fee of $25 for any check returned by your bank.

Late Cancellation/Missed Appointment fee is $90 or loss of a session if you have purchased a colon hydrotherapy package. *(Late Cancellation is notification in less than 24 hours of the scheduled appointment.)*

Exceptions to the policy are when a reasonable emergency arises. “Reasonable” shall be decided by the Neck, Back & Beyond practitioners upon discussion with the patient.

Name and address of financially responsible party:

_____

NAME

_____

STREET

_____

CITY, STATE, ZIP

_____

EMAIL PHONE NUMBER

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE