CANCELLATION POLICY

(Will be enforced!)

Every effort is made to keep our schedule running as efficiently as possible, so we respectfully ask patients to be prompt and keep their appointments. Our standard office policy regarding appointments is as follows:

We try to remind patients by telephone prior to the appointment, but **PLEASE DO NOT DEPEND ON THIS COURTESY.** All appointments are considered confirmed at the time they are made.

PHYSICIAN SERVICES and/or LIMBIC STRESS ASSESSMENT VISITS.
We reserve the right to CHARGE YOU for office visits cancelled or broken without a **48 HOUR** Advance notice for any physician services and/or Limbic Stress Assessment visits.

ALL OTHER SERVICES
We reserve the right to CHARGE YOU for office visits cancelled or broken without **a 24 HOUR** Cancellation notice for all other services including spa services. Please call **us 48 or 24 hours in advance** (depending on services, *see above*) if you cannot keep the appointment or your credit card **will** be charged. Because a substantial amount of time has been set aside, you will be charged ½ of the regular rate of that particular service for a missed appointment. If you cancel in less than 24 or 48 hrs., (depending on service) but 'reschedule' same appt. at that time, then no fees will be applied.

Before your initial appointment, your credit card number was given to hold your appointment.
If your credit card fails for any reason, **you will be billed and any and all past due balances** will be collected before your next appointment or you will not be able to schedule your next appointment.

ALL Cancellations MUST be DURING Business HOURS ONLY and through front office personnel or administration. We will not accept cancellation appointments left on our voicemail.

Thank you for your cooperation in allowing us to better service all of our patient/client family.
By signing below, I signify that I have read this cancellation policy and that I understand and agree with this policy.

Signature of Client or responsible party:____ Date:________________________

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your visit being successful. Please understand that payment of your bill is considered part of your visit/consult. The following is a statement of our Financial Policy, which we require you to read and sign prior to any visit at our facility. All patients must complete our Patient Information Sheet prior to seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND AMERICAN EXPRESS & DISCOVER CARD.

REGARDING CASH

It is under your understanding, by signing this document, that you are responsible for any and all charges incurred as a result of your care. This includes, but is not limited to: Consultation charges, testing, bloodwork, homeopathics, supplements, and retail store items. Payment for services are due upon the time of visit or purchase. There will be no exceptions made to the terms of this signed document.

REGARDING INSURANCE

We **do not bill insurance** for any of our nutritional testing services, thermographic or spa services related to Holistic Options, Inc. If you choose to submit your own claim, be aware that we do not provide CPT or Procedure codes in order for you to process your claim or invoice.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of this Financial Policy.

Signature of Client or responsible party:____ Date:________________________

635 Primera Blvd., Ste: 101
Lake Mary, FL 32746
407-333-1059