KINSEI: Authorization and Agreements

I have read and understand and agree to the Policies and Procedures of KINSEI**.** I realize that unless other arrangements have been made with the doctor payment is due at the time the services are rendered. **I further understand that cancellation without 24 hours notice will be charged to my credit card.**

If I have health and accident insurance, I understand that such insurance policies are arrangements between an insurance carrier and me. It is my responsibility to file my insurance claims. Regardless of what the insurance company reimburses me for, I understand that services received are charged directly to me.

Patient Name: _____

Patient Signature: _____ **Date:**_____

Credit Card # _____ **Exp. Date:**_____

Guardian or Spouse: _____ **Date:**_____

Signature Authorizing Care: _____ **Date:**_____