Thank you for choosing K Primary Care & Medical Nutrition Center for your medical needs. We are committed to providing you with quality medical care. We ask that you read and sign this form to acknowledge your understanding of our office policies.

Patient Responsibilities:

- We request that you provide your current health insurance card at every visit and inform the staff of any changes in your personal information.
- We will bill your insurance but you will be responsible for payment of treatment received at our office that is not paid or covered by your insurance.
- We require that you pay all outstanding balances prior to your next doctor's visit.
- Please note that if your insurance requires a referral or pre-authorization, it is your responsibility to obtain the referral or pre-authorization.
- You are responsible for payment of co-pays, co-insurance and deductibles. Co-pays are due at the time of service.
- If you do not have insurance, we require that you pay for the visit at the time of service.
- We reserve the right to charge a $25 fee for missed appointments that are not cancelled at least 24 hours in advance.
- There is $30 charge for returned checks.

By my signature below, I agree that I have read, understood and will abide by the office policies of K Primary Care & Medical Nutrition Center.

Patient Name: ____

Patient Signature: ____

Date: __________________________________