**PAYMENT AGREEMENT**

I understand that payment for services received at the clinic is my responsibility. If my claim is to be submitted to an outside agency for payment, and for any reason the third party payer such as WSIB, insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CANCELLATION AGREEMENT**

I understand that I am responsible for providing 24 hours notice for appointment cancellations. [If you do not provide adequate notice to cancel your appointment, we lose two patients – you and the person who could have been treated in that time slot.]

I acknowledge that if I do not provide 24 hours notice, I may be charged a cancellation fee. I understand that third party funders may not pay for cancellation charges I may incur, and that I may be personally responsible for paying such cancellation charges.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_