MY METRO MEDICINE

Effective August 11, 2015

Patient Agreement Form

As a patient of My Metro Medicine, I hereby understand and agree to the following:

- I am required to provide 24 hours minimum notice should I need to cancel my appointment, or I will be charged for the full cost.
- I will be added to the My Metro Medicine newsletter, email contact list, and additional publications, which I can cancel at anytime.
- I will be responsible for a $35.00 payment for all returned checks.
- I will complete all purchased sessions within six months of the date of purchase.

_____ _____

Email Address Phone #

_____ _____

Print Name Date

_____

Signature