Payment Agreement

Dr. Jessica Kooima, PLLC

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Mesa, AZ 85210

480-730-6222; 480-889-5566 fax

Please read the following and fill out the form completely.

- Your signature indicates you understand that if you do not attend a scheduled appointment, you will be charged the regular cost of the appointment you reserved unless you cancelled at least 24 hours in advance, business days – Monday through Friday. For missed appointments with no notice given, $25 will be charged. You can always call our office (24-hours a day) to leave a voicemail to cancel an appointment. Please know that we adhere strictly to the time requirements and payment agreement.
- Your signature indicates you understand that any payment of fees is ultimately your responsibility, not an insurance company's or any other 3rd-party payer's responsibility, and that you will be paying for any missed appointments.
- Payments are expected at the time of service or in advance of service. Your signature indicates you understand that you must pay with cash, check, or debit/credit card at the time of service. Please note that there is a $25.00 fee for any returned checks for non-sufficient funds.
- Lab fees are billed separately from the Laboratories. It is your responsibility to provide payment directly to the laboratories.
- Request for Medical Records – When requesting a copy of your records or for records to be sent to3rd party, you will need to sign a release. We have 7 to 10 business days to fulfill the request. The fee is $20 for the first 20 pages then .25 per page.

Current Cash Fees for Services:

Initial Assessment - New Patients (1 hour)	$199.00	Established Patients – office visit (30 minutes)	$95.00
Vaccinations & Supplements – prices vary		Phone or Email Communications – per 15 minutes	$50.00

I understand and agree to comply with this Payment Agreement.

Patient's Signature: _____ Date: _____

Client/Guardian:_____ Sign:_____Date:_____
Print Name Signature

Client Name:_____ SS# (or Insurance ID#):_____ If Different Than Above

Day Phone:_____ Evening Phone:_____ Cell Phone:_____

Please Circle: VISA / MASTERCARD AMEX Card Number:_____

Expiration:_____ Card Verification Number:_____ Billing Zip Code:_____

Address:_____

*Your credit card information will be held confidential and this information will be secured in your client file.