

Request for Refund

Date: _____

Name: _____

Address (Where to mail the refund): _____

Phone: _____ Email: _____

Amount of refund requested: \$ _____

Please allow 7-14 business days to verify this amount and refund to be processed.

(Optional Questions)

1) Do you mind sharing the reason you were not satisfied with the services/care?

2) What could we have done differently to make your experience satisfactory?

Signature of Patient _____

(For office use only)

Amount verified by: _____ Date _____

Refund authorized by: _____ Date _____

Refund mailed by: _____ Date _____