Cruz Clinic
17177 North Laurel Park Dr. Suite 131
Livonia, Michigan 48152

# Payment for Service Agreement

**Client Name:**_______________________________ **Date of Birth:**______________

As a new client of Cruz Clinic I understand and agree to the following:

1. Cruz Clinic verifies my insurance benefits as a **courtesy only** and this is not a guarantee of payment.

2. Insurance companies often misquote benefits and this is not the fault of Cruz Clinic.

3. It is my responsibility to know my individual insurance benefits.

4. I understand that even if the insurance company misquotes my benefits, **I am still responsible for paying the appropriate amount for the services I receive at Cruz Clinic.**

5. Cruz Clinic charges a **"No Show/Late Cancel" fee of $50** if I do not call with at least **24 hours notice** of my appointment to cancel or change the appointment time.

6. **This "No Show/Late Cancel" fee is not refundable** by my insurance company and I am solely responsible for paying this amount.

7. Cruz Clinic utilizes an automated system which makes reminder calls the day prior to your appointment.

   ___ Yes, I would like to be included in this reminder call service at the following number ______________________.
   ___No, I would prefer not to get a reminder call.

8. I understand that this automated call is strictly a courtesy call, and I further understand that **I am still responsible** for a "No Show/Late Cancel" fee even if this automated call reaches me less than 24 hours prior to my appointment time, and/or if I do not receive this automated call.

I have read and agree to the above statement:

_________________________ _______________
Client/Guardian Signature Date

_________________________ _______________
Witness Signature Date