Request for Refund

	Date:
Name:	
Address (Where to mail the refund):	
Phone:	Email:
Amount of refund requested: \$	and refund to be processed.
(Optional Questions)	
1) Do you mind sharing the reas	on you were not satisfied with the services/care?
2) What could we have done diff	ferently to make your experience satisfactory?
Signature of Patient	
(For office use only)	
Amount verified by:	Date
Refund authorized by:	Date
Refund mailed by:	Date