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_____