



WHITE MOUNTAIN CLINIC

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient's Name: _____
First Middle Last

Signature: _____
Responsible party signs if patient is a minor

Date: _____

Financial Agreement:

- ☞ Payment is due at the time of service unless other arrangements have been made.

- ☞ White Mountain Clinic does not bill insurance companies, but can provide me with a service summary receipt if I choose to bill insurance myself.

- ☞ White Mountain Clinic accepts checks and cash for payment; checks may be made out to Dr. Lynne David.

- ☞ I understand that I may be charged in full for appointment cancellations with less than 24 hour notice.

- ☞ I understand that if White Mountain Clinic cancels an appointment with me less than 24 hour notice, I will not be charged for my next appointment.

- ☞ I understand that the cost for patient visits and services are subject to change and that I will be notified about patient visit and service fee changes prior to my appointment.

- ☞ I may not necessarily be informed of changes in the price of medicinal items prior to an appointment.

Holistic Health care

Naturopathic Medicine

Classical Chinese Medicine

Prevention

Treat the Whole Person

Treat the Cause

Education

Healing Power of Nature

Do No Harm

WHITE MOUNTAIN CLINIC

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