## **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 an	nount 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	e 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