H E A L I N G
T H E
E Y E
& Wellness Center
Dr. Edward C. Kondrot, MD (H), CCH, DHt.
2001 W Camelback Rd Suite 255
Phoenix, AZ 85015

FINANCIAL AGREEMENT

Name ____

Street ____

City ______________________________ State__________ Zip ___________

Daytime Phone ______________________ Evening ______________________

E-Mail

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I understand that payment is expected at time services are rendered unless prior financial arrangements have been made. I understand that Healing the Eye and Wellness Center, the offices of Dr. Edward C. Kondrot, MD, (H), CCH, DHt will NOT process or assist in any insurance or medical billing or claims. I understand that it is my sole financial responsibility to Healing the Eye and Wellness Center, Dr. Ed-ward C. Kondrot, MD (H), CCH, DHt for all charges incurred.

I also understand that Healing the Eye and Wellness Center has the right to assess a cancellation charge to my billing information of up to ½ of my consultation fee for all appointments not cancelled with 2 business day's prior notice.

______________________________________ ____________________
Patient Signature Date