Harmony Community Clinic
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Financial Policy and Payment Agreement

Patient name (print) _____ Date of birth _____ Date _____

1. Payment at time of service

Payment is due at the time of service unless other arrangements are made in advance. We accept cash, debit and credit cards, and other methods posted at the front desk.

I agree to pay for services at the time they are provided. _____ Initials

2. Insurance

Harmony Community Clinic may not participate with all insurance plans. Weight management, IV therapy, vitamin and peptide injections, most hormone treatments, and all aesthetic procedures are usually not covered by insurance and are self-pay. If I use insurance, I am responsible for copays, coinsurance, deductibles, and any services my plan does not cover. Upon request, the clinic can provide an itemized receipt (superbill) that I may submit to my insurance on my own.

3. Good Faith Estimate

If I do not have insurance or I am not using insurance, I have the right under federal law to receive a Good Faith Estimate of the expected charges for scheduled services before I receive them. I may ask for one at any time. Under Florida law, I may also request a reasonable estimate of charges before treatment.

I understand my right to a Good Faith Estimate. _____ Initials

4. Medications, packages, and refunds

- Compounded and other prescription medications are prepared or dispensed specifically for me. Once dispensed, they cannot be returned or refunded.
- Prepaid packages, programs, and memberships follow the written terms given at the time of purchase.
- Results of treatment are not guaranteed, and dissatisfaction with results is not grounds for a refund of services already provided.

I understand the refund policy for medications and services. _____ Initials

5. Cancellations and missed appointments

Please give at least 24 hours' notice to cancel or reschedule. Late cancellations (less than 24 hours) and missed appointments may be charged a fee of $15. Deposits for aesthetic appointments may be applied toward this fee.

I understand the cancellation and missed appointment policy. _____ Initials

6. Returned payments and unpaid balances

A fee of $15 may be charged for returned payments. Unpaid balances may be sent to a collection agency after reasonable notice, and I will be responsible for reasonable collection costs as allowed by law.

7. Card on file (optional)

☐ I authorize Harmony Community Clinic to keep my card on file and charge it for balances, late-cancellation fees, and recurring program payments I have agreed to. My card information is stored securely by the payment processor, not on this form.

I have read and agree to this financial policy. _____ Initials

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.