



5454 Wisconsin Avenue  
Suite 1435  
Chevy Chase, MD 20815

## Patient Agreement

I would like to welcome you to my practice and thank you for your interest in my counseling services in Nutritional and Family Medicine and Preventive Care. The following is an agreement between myself (payee), Heike Bailin, MD and the Patient or individual taking the responsibility for payment, if someone different other than the patient. In this agreement the words “you”, “your”, and “yours” mean the Patient or individual taking responsibility for payment (payor), if someone different other than the patient. The word “account” means the account that has been established in your name to which charges are made and payments are credited. By executing this agreement you are agreeing to pay for all services received.

**Payments:** Payment for specified (i.e. billed) fee(s) for services is expected at the time of services rendered unless prior arrangements have been made between you and myself. I currently accept personal checks (with government-issued identification), cashier’s checks and cash. As banks charge the payee’s account for any checks drawn payors’ accounts with insufficient funds I will assess a \$25 fee for any returned checks. You agree to pay this fee in addition to the scheduled payment in case of a returned check.

**Past due accounts:** If your account becomes past due, I will take the necessary steps to collect this debt. If I have to refer your account to a collection agency, you agree to pay all the collection costs that are incurred.

**Missed appointments:** Given the nature of my practice I have a 48-hour notice appointment cancellation policy. This must occur by telephone (202.415.0257) or e-mail ([drbailin@ownyourshape.com](mailto:drbailin@ownyourshape.com)). If you cancel your appointment or do not realize any scheduled visit without cancellation or notice you are responsible for the full fee.

**Effective date:** Your signature on this agreement indicates you agree to all of the terms and conditions in this agreement. The agreement is effective as of the date signed and dated below. Thank you for your consideration.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_