

WESTOVER HILLS CLINIC
11212 State Highway 151, Suite 190
San Antonio, Texas 78251
Telephone (210) 523-9933
Fax (210) 647-0242

Name _____ Birthdate _____

No show policy/cancellations

While we are reasonable and understand that daily emergencies and obligations cause people to miss appointments, we have to be fair to others that may also need appointment slots.

Missing 3 appointments by not showing up without calling 24 hours in advance, or cancelling more than 3 appointments may cause me to be discharged from care @ Westover Hills Clinic or incur an administrative penalty.

I have read and understand the cancellation and no show policy.

Signature _____ Date _____

Financial Policy

We are committed to meeting your healthcare needs and appreciate your confidence. To assist you in receiving care, we will verify your insurance coverage and co-payments. However, the financial responsibility lies with you as the recipient of the services. Any fees not covered such as deductibles and co-payments, and any services not covered by your insurer will be billed to you. I have read, understand and I authorize my insurer to pay benefits directly to Westover Hills Clinic. Furthermore, I understand that I am responsible for any amount not covered by my insurer.

Signed _____ Date _____

Consent to Treatment

I authorize Westover Hills Clinic, PA and personnel to provide me with healthcare services as deemed necessary with appropriate exams, medications, and testing.

Signed _____ Date _____

