



INSURANCE ACKNOWLEDGEMENT

Today's Date: _____

Your Name (First, Middle, & Last) _____

Home Address: (Street) _____ City: _____

State: _____ Zip Code: _____

Telephone Number: _____ Home Cell Work

Primary Insurance Carrier: _____

Effective Date of Policy: _____

Secondary Insurance Carrier: _____

Effective Date of Policy: _____

I _____ acknowledge the information I have provided is accurate and true. I acknowledge that I am personally responsible and will be charged for any and all charges not covered by the insurance policies that I have provided including the full payment of \$175.00 for a late arrival or a missed appointment with less than a 24-hour notice.

Printed Name of Client: _____

Signature of Client: _____

Date: _____

5151 N Palm Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733

