## **Request for Refund**

	Ι	Date:	
Name:			
Address (Where to mail the refund):			
Phone:			
Amount of refund requested: \$Please allow 7-14 business days to verify this a	imount and refund to be processed.		
(Optional Questions)			
1) Do you mind sharing the	reason you were not satis	fied with the services/care	?
2) What could we have don	e differently to make your	experience satisfactory?	
Signature of Patient			
(For office use only)			
Amount verified by:		Date	
Refund authorized by:		Date	
Patind mailed by:		Data	