

# Request for Refund

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

Name: \_\_\_\_\_

Address (Where to mail the refund): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Amount of refund requested: \$ \_\_\_\_\_  
Please allow 7-14 business days to verify this amount and refund to be processed.

## (Optional Questions)

1) Do you mind sharing the reason you were not satisfied with the services/care?

2) What could we have done differently to make your experience satisfactory?

Signature of Patient \_\_\_\_\_

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## (For office use only)

Amount verified by: \_\_\_\_\_ Date \_\_\_\_\_

Refund authorized by: \_\_\_\_\_ Date \_\_\_\_\_

Refund mailed by: \_\_\_\_\_ Date \_\_\_\_\_