

DR. WESLEY M. KOBAYASHI

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MISSED APPOINTMENTS

When a patient misses a scheduled appointment, it deprives our office the opportunity to provide services to others needing our care. Often times, there is a waiting list of patients desiring treatment in our office and have to wait several weeks to come in. We try to accommodate all our patients and ask that if you foresee a reason that you are unable to keep your appointment we request that you give this office 24-hour cancellation notice so that we may offer the appointment to someone else. We do make every effort to remind you of your scheduled appointment. ***In the event that a patient misses an appointment, it is our policy to charge the patient \$30.00 for the missed office visit. This fee is not covered under insurance and will be the patients' responsibility to pay this fee.***

Please help us better serve our patients by keeping scheduled appointments or call 24-hours in advance to cancel your appointment.

FORMS

Disability forms and/or employer disability forms, leave of absence forms will be assessed a \$10.00 fee. This is payable in advance. All envelopes should be complete with return address and proper postage.

ORTHOTICS

Image Orthotics is partially owned by Dr. Kobayashi. Please be assured that we will make every effort to fit you accordingly with orthotics. Once the orthotics are received in the office we will notify you as such and an appointment will be made to have these fitted. Please note that we are unable to store orthotics for more than 30 days, at which time a storage fee will be assessed. Also note, that should you request another set of orthotics this must be done within 6 months from the day of casting. The lab destroys casts after 6 months. ***It is the patient's responsibility to know if orthotics are covered under their insurance policy. All cash paying patients must leave a \$100.00 deposit at the time orthotics are casted and the remainder due at time of dispensal unless other financial arrangements have been made in advance.***

I acknowledge that I understand and agree to the above.

Patient's Signature

Date