Please note carefully that Inder Bhanver MD PLLC is charging you a fees for the doctor's time to conduct an evaluation to determine appropriate diagnosis and treatment. THIS IS NOT A GUARANTEE THAT YOU WILL RECEIVE ANY PARTICULAR DIAGNOSIS, TREATMENT OR MEDICATIONS. Your diagnosis and treatment cannot be pre-determined before the doctor has seen you. If you do not agree with or like the doctor's diagnosis, or treatment plan, you will not be entitled to any refunds of any or all portions of your payment.

By my name and / or signature below, I certify that I have read and will abide by the above policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Guardian/ Representative Name Signature Date

 (if applicable)

Relationship of Guardian / Representative to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_