Jan Gagnon, ND
12503 SE Mill Plain Blvd. Suite 215A
Vancouver, WA 98684 360-448-6353

Terms of Service
Name _____ Birthdate _____

Consent to Treatment for Health Care
I authorize consent for treatment and diagnosis by Jan Gagnon, ND. I understand that I have the right to refuse any
treatment and to be treated with respect and dignity, and to the assurance of the privacy of my records.

Payment Policy
Payment is required at the time of service. In the case of private health insurance, we will provide insurance forms
and codes for you to obtain reimbursement. We do accept credit and debit cards.

Cancellation Policy
We require twenty-four hours notice for cancellations. If you cancel with less than six hours notice, you will be
charged 50% of the total charges for the scheduled visit. If you fail to keep your appointment, and do not call
to cancel, you will be charged in full for the visit (100% of charges).

Health Insurance Agreement
I understand that all health insurance policies are an arrangement between my insurance carrier and myself. I
authorize the release of any medical information necessary to process my insurance claim and I authorize payment of
any medical benefits owed to this office for professional services rendered.
If you have any questions concerning any of the above consent, policy or agreement issues, please feel free to ask.

I have read and understand the above Consent to Treatment, Payment Policy, Cancellation Policy and Health Insurance Agreement. I agree to follow them while utilizing the services of Jan Gagnon, ND.

Patient signature _____ Date_____
(18 years or older)
Parent, guardian, responsible party _____
Date_____
Witness _____Date _____