Daniel Cameron, MD, MPH and Associates
344 Main Street, Suite 104
Mt. Kisco, New York 10549
Tel: 914-666-6271 Fax 914-666-6271

Date: _____

Hello. Thank you for your interest in becoming our patient. Dr. Daniel Cameron is a nationally recognized leader for his expertise in the diagnosis and treatment of Lyme disease and other tick-borne illnesses.

We're committed to making things easy for you, but before we begin, we would appreciate it if you would complete the following demographic information, credit card authorization, and refund policy

Once this form has been completed, please return it to:

1. Dr. Cameron using PDFfiller at https://danielcameronmd.com/lyme-new-patients/
2. or email Info@DanielCameronMD.com
3. or Fax 914-666-6271 to begin the registration process.

Call my office after completing this form to schedule an appointment.

Respectively,

Daniel Cameron

1. Demographic

Name (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Address: _____ City _____ State _____ Zip _____

Cellular#: _____ Home#: _____

Email address: _____ SS# _____

Birth Date: _____ Age: _____ Gender : ☐ M ☐ F

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2. Credit Card Authorization

Please complete this authorization form and return it to us. All information will remain confidential.

Cardholder name: _____

Billing address: _____

Credit card type: ___ Visa ___ Master Card ___ Discover ___ Am Express ___ other

Credit card number: _____

Expiration number: _____

Card identification number (3 digits located on the back of the card): ____

Card holder's name (please print): _____

Card holder's signature: _____

Date: _____

3. No refund policy

By signing this No Refund Policy, I agree that any service(s) I receive at Dr. Daniel Cameron and Associates is final. I understand any and all service(s) received will not be refunded or issued a credit.

I also understand that if I decide to cancel or postpone any service(s), I will forfeit all monies paid: including my deposits and/or payments I have already paid. I also understand that if I decided not to notify Dr. Daniel Cameron and Associates about postponing any services, I will be responsible for paying a fee.

By signing this No Refund Policy, I understand and agree to all terms and conditions of here said policy. All of my questions have been answered regarding this No Refund Policy.

Patient Signature _____ Date _____

Parent if patient is a minor _____ Date _____