[Clinic Name]
[Clinic Address]
[Phone Number]
[Email Address]

[Date]

Dear [Patient Name],

Welcome to [Clinic Name]. To ensure we provide the best care for all our patients, please review our clinic policies and procedures below:

1. Appointments and Cancellations

We require at least [24/48] hours' notice for any appointment cancellations or rescheduling. Failure to provide notice may result in a "No-Show" fee of $[Amount].

2. Arrival Time

Please arrive [15] minutes before your scheduled appointment time to complete any necessary paperwork. If you are more than [15] minutes late, we may need to reschedule your appointment.

3. Payment and Insurance

Co-payments and outstanding balances are due at the time of service. We accept [Cash, Credit Cards, Checks]. It is your responsibility to verify that our clinic is in-network with your insurance provider.

4. Prescription Refills

Please allow [2-3] business days for prescription refill requests. Refills will not be processed after hours or on weekends.

5. Code of Conduct

Our clinic maintains a zero-tolerance policy for aggressive, disrespectful, or abusive behavior toward our staff or other patients.

6. Privacy (HIPAA)

Your medical records are strictly confidential. We will not release your information to any third party without your written consent, except as required by law.

By signing below, you acknowledge that you have read, understood, and agree to follow these policies.

_____
Patient Signature

_____
Date

Sincerely,

[Clinic Manager/Doctor Name]
[Clinic Name]