SHERI SPIRT, M.D.

PSYCHIATRY

16 East 96th Street Unit 1A

NEW YORK, N.Y. 10128

(212) 595-6901

[SSDR18@AOL.COM](mailto:SSDR18@AOL.COM)

WWW.DRSHERISPIRT.com

**Acknowledgment of Office Policy**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have read and understand the office policy. I understand that Dr. Spirt has a busy schedule and that if I miss my appointment time I will be responsible for the full payment for the visit if Dr. Spirt is not able to accommodate me after my scheduled appointment.

Patient name

Patient signature

Date

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Witness