CANCELLATION POLICY & PATIENT AGREEMENT

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will enable another patient who is waiting for an appointment to be scheduled in that time slot.

Cancellations made with less than 24 hours' notice are considered LATE CANCELLATIONS, since we are unable to offer that slot to other patients.

LATE CANCELLATIONS will be subject to a $20 cancellation fee.

Patients who fail to show up for their appointment without calling to cancel will be considered a NO SHOW.

A NO SHOW will be subject to a $30 missed appointment fee. (A full cash visit fee is normally $49.)

Patients who NO SHOW two (2) or more times in a 12-month period, will be denied any future appointments.

The LATE CANCELLATION and NO SHOW fees are the sole responsibility of the patient and must be paid in full prior to scheduling the next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding, mutual respect and good communication. We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to the LATE CANCELLATION and NO SHOW Policy.

_____ _____

Patient Name (Please Print) Date of birth

_____ _____

Signature of Patient or Patient Representative Date

_____ _____ _____

Credit Card # Expiration CV#

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