



## CANCELLATION/LATE POLICY

**\*\*\*Please be advised of our Cancellation/Late Policy.**

Cancellations must be made at least 24 hours prior to scheduled appointment. Patients arriving fifteen minutes late, no shows or not allowing 24 hours notice to cancel will be charged a rescheduling fee. Our rescheduling fee is \$50.00.

Please provide a credit card below:

MasterCard      Visa      American Express

Name on Card - \_\_\_\_\_  
Please Print

Card Number - \_\_\_\_\_

3 digits on back of card - \_\_\_\_\_

Expiration Date - \_\_\_\_\_

We will keep this information in your ***confidential*** patient file. Your card will not be charged unless you do not show at your scheduled time or give 24 hours notice to cancel or reschedule. We may also enforce this policy if you arrive 15 minutes late and we do not have time to accommodate your procedure. Please sign below to acknowledge you have been advised and accept the terms of our Cancellation/Late Policy.

Thank you in advance for your cooperation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date