CANCELLATION POLICY

NAME:_____**BIRTHDAY:**_____

ADDRESS:_____**PHONE:**_____

_____**CELL:**_____**WORK**_____

Your signature indicates that you have read and understood all the items below.

1) PAYMENT FOR SERVICES: Payment is due at the time the services are rendered unless other arrangements are made.

2) INSURANCE: If you are covered under an insurance policy, we will submit the claims for you. You will be responsible for any deductibles and copayments which may apply under your policy. Please remember that YOU, NOT YOUR INSURANCE CARRIER, are responsible for the total payment of your account.

3) 24-HOUR NOTICE: An appointment is a commitment of time. If you find that you must cancel or postpone a scheduled appointment, please notify the office 24 hours in advance. If notice is not received a FULL 24-hours prior to your scheduled appointment time, you will be charged for the appointment.

I understand the above items, and I agree to each of them.

Signed:_____

Date:_____