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**CANCELLATION POLICY/FEE**

I understand and agree that if I fail to show for a scheduled appointment or do not notify the clinic 24 business hours in advance, I may be charged a fee of $25.00. For a procedural appointment such as surgery or a cosmetic/laser procedure, I must cancel 48 business hours in advance or I may be charged a fee of $75.00. This fee is required to be paid prior to scheduling another appointment.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(parent/legal guardian if patient is under 18)**