



## NO-SHOW POLICY

Dear Patient:

We understand that there are often legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient who needs to be seen.

This letter is to notify you that failure to provide a 12 hour notice of cancellation will result in a \$25 cancellation fee for regular appointments and a \$75 fee for surgical and cosmetic appointments. This will be billed to you directly and cannot be filed to your insurance.

**I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE NOTIFICATION AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.**

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

If patient is under age 18 or unable to authorize consent:

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_