CANCELLATION POLICY

Please contact us at least 24 hours to cancel or reschedule your appointment. We enforce a strict cancellation policy and you will be charged the full amount ($150.00) for your scheduled appointment time if cancellation or rescheduling is less than 24 hours. Thank you for your time and understanding.

I_____(please print name) have read the above policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel or reschedule with less then 24 hours notice.

Signed (patient signature)_____

Date:_____

Credit Card Authorization

Credit Card Number:_____

Expiration Date:_____ CVV#:_____

Billing Address of Credit Card

Street Address: _____

City, State, Zip Code: _____