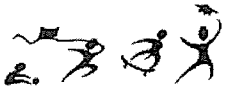

No-Show/ Cancellation Acknowledgment

Patient Name _____ DOB _____

When an appointment is made, we require that it is kept or cancelled prior to the appointment time.

I understand that if I fail to cancel or reschedule an appointment, I will be charged a **$15.00** "no-show fee". I understand that this "no-show fee" is not billable through my insurance company and that it MUST be paid prior to the next appointment.

I also understand that after three "no-shows", we may consider permanent dismissal of the entire family from our practice.

Parent/Guardian (printed) _____ Relationship to patient _____

Patient/Guardian signature _____ Date _____