

Dobbs Ferry Chiropractic
& Holistic Health Center

63 Main Street, Dobbs Ferry, NY
T: 914.693.4545 / F: 914.231.6672

MISSED APPOINTMENT POLICY

I _____, understand and agree that I am personally responsible for payment for appointments missed without notice in advance, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Missed appointments are billed at \$35/visit.

A photocopy of this form shall be valid as the original.

PATIENT SIGNATURE: _____
(Parent/Guardian if patient is a minor)

DATE SIGNED: _____