MISSED APPOINTMENT POLICY

I _____, understand and agree that I am personally responsible for payment for appointments missed without 24 hours notice, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Given that we see one patient at a time, **missed appointments are billed *in full.***

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

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

DATE SIGNED: _____