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Appointment Cancellation Policy

I acknowledge my appointment for _____ must be held with a valid credit card. Cancellation or change of appointment must be made 48 hours in advance. We reserve the right to charge 10% of the total fee for any missed appointments. The approximate fees for my appointment on ___/___/___ is \$_____.

Issuing Bank _____

Name on Card _____

Card Number _____ Sec Code _____

Expiration _____

Billing Zip Code _____

Print Patient Name _____

Patient Signature _____ Date _____