COMMUNICATION
FOUNDATIONS

Patient Name:_____

Cancellation Policy

ALL APPOINTMENTS MUST BE CANCELED AT LEAST **24 HOURS** BEFORE THE SCHEUDELD TIME. APPOINTMENTS THAT ARE NOT CANCELED AT LEAST 24 HOURS PRIOR, WILL BE SUBJECTED TO A $65 FEE TO BE PAID BY THE PATIENT.

THANK YOU FOR YOUR UNDERSTANDING IN HELPING US BEST MANAGE THERAPY SCHEDULES.

I understand that I am ultimately responsible for the $65.00 fee applied if appointments are canceled on the same day of scheduled service.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Patient Representative Date
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

1032 Main Street Φ Fishkill Φ New York Φ 12524
845-897-3330 *phone* Φ 845-897-3753 *facsimile*