



OFFICE USE ONLY
MR# _____

CANCELLATION POLICY

Cary Healthcare Associates, P.A. understands that occasionally, you will be unable to attend your scheduled appointment. When this happens, we ask that you kindly notify our office as early as possible, so that we may open your appointment time to patients who may need more immediate care. We request that, when possible, you provide 24 hours notice.

Unfortunately, we have frequently experienced patients missing their appointments without any advance notice to Cary Healthcare, P.A. Such occurrences are detrimental to both our business and to our other patients waiting for an appointment.

Please be notified that a \$50.00 fee will be charged when an appointment is missed without advance notice.

Cary Healthcare Associates, P.A. reserves the right to dismiss from the practice any patients who frequently miss scheduled appointments.



I have read and understand the cancellation policy stated above and agree to accept responsibility as described.

Patient Name (Please Print)

Patient Signature

Date

Responsible Party, if Other (Please Print)

Responsible Party Signature, if Other

Date

**Refusal to commit to our policy by declining to sign this form will result in termination from the practice.*