Appointment Cancellation Policy

By signing my name below, I understand that an extended appointment has been scheduled for my treatment.

I also understand that if I am unable to keep the appointment time, I agree to give a minimum of three (3) working days' notice. If the appointment is cancelled with less than three (3) working days' notice, I will be charged a fee of 25% of the total surgery fee. The cancellation policy will also apply to any future appointments I might have.

I also understand that I am to refrain from drinking alcohol or using non-prescription drugs for 24 hours prior to treatment. If this is not followed I understand my appointment will be cancelled and subject to the above fee.

Name: ____

Date: ____

Witness: ____