

# CANCELLATION POLICY

PATIENT NAME: \_\_\_\_\_

Effective February 15, 2016, our policy is as follows:

We set aside dedicated time in our office for your hearing care appointment. If you find it necessary to cancel, please provide notice 24 hours in advance. Without proper notice, you will be charged a \$75.00 fee for your scheduled office visit.

\_\_\_\_\_  
**Patient/Responsible Party Signature**

\_\_\_\_\_  
**Date**