



CANCELLATION POLICY

I agree to attend all scheduled appointment. I understand that there may be circumstances in where I may need to cancel or reschedule an appointment, and may do so **within 24 hours** notice. **Failure to do so will result in a bill for service rendered, which is \$75 for therapy patients and \$100 for patients undergoing testing.**

Exceptions may be made in the case of weather, emergency , or illness.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date