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 $69 for patients with United Health, $50 fee for self pay patients (therapy) and $100 (assessment).**

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

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date