2800 Ross Clark Circle, Suite 2
Dothan, Alabama 36301
334-699-7546

No Show Policy

Patient Name: _______________________________________ Date of Birth: __________________

FOR ALL PATIENTS:
In order to deliver quality care in a timely manner, we ask that you please provide a 24-hour notice for all cancellations.

A $25 “no show” fee will be charged to your account if a 24-hour notice is not provided. We understand that situations may arise that prevent you from making your appointment, but repeated occurrences may be cause for dismissal from our care.

In signing this form you are acknowledging that you have read and understand this policy. If you have questions regarding this, please contact our office. Thank you.

_____________________________________ ________________________
Patient/Parent/Guardian Signature Date

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Patient/Parent/Guardian Name Printed