

Patient Appointment Reminders:

To maximize your therapy experience and improve office efficiency, we would like to send you appointment reminders.

Please check the best method to contact you:

_____ **Voice Calls: Phone Number:** _____

_____ **Text Message: Phone Number:** _____

_____ **E-Mail:** _____

Please sign that we have permission to leave a voicemail / E-mail you regarding your appointment or other treatment matters.

Cancellation/No Show Policy: We require a 24 hour notice if you need to cancel an appointment. Due limited availability of appointments, we charge a \$50 fee for any cancellations under 24 hrs and if you fail to show for your appointment you will be charged and removed from the schedule.

Patient Signature (Parent/Guardian if necessary) _____ Date: _____