ALLSKIN
DERMATOLOGY
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Patient's Name_____ DOB_____

No Show/Cancellation/Copay Policy

To cancel or reschedule an appointment, patients must contact the office between 9AM and 12 noon or 1:30 PM and 5PM, at least **24 hours prior to the appointment** so that we may offer your appointment time to a patient in need. Monday appointments must be canceled or rescheduled by the Friday before.

If the office does not receive **24** hour notice a **$85.00** no show fee will be assessed.

Copays are due at time of service a **$25.00** billing fee will be charged if you do not have your copay at time of service.

Please sign below stating that you have read and acknowledge our cancellation policy.

_____ _____
Signature Patient/ Parent or Guardian Date

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the Notice of

Privacy Practices for AllSkin Dermatology.

_____ _____
Signature of Patient Date