

6005 Salem Road S.W.
Rochester, MN 55902
Telephone: (507)281-3033
Fax: (507)281-7692

CANCELLATION POLICY

CLIENT NAME: _____

DOB: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____

If you need to change or cancel an appointment, please do so at least 24 hours in advance of the appointment time. If you fail to keep an appointment, you may be charged the entire customary rate, unless prohibited by your coverage.
Insurance will not pay for these charges.

I have read and understand the above policy.

Signature of Client

Date

Signature of parent/guardian if client is a minor and
unable to sign

Date