



5100 S. Dixie Hwy #9, West Palm Beach, FL 33405

561-547-7878

## Cancellation, Reschedule and No Show Policy

Thank you for choosing Matthews Chiropractic, Acupuncture and Rehab, to provide your chiropractic and massage needs. When a patient doesn't make it to a scheduled appointment, this is time another patient could have taken to receive the care they need. Please help us deliver the care our patients need as efficiently as possible. Please read the following policies, and then sign your name at the bottom of the page.

### Chiropractic Cancellation, Reschedule and No Show Policy:

If you need to **cancel or reschedule** a Chiropractic appointment, please call us ASAP (**at least 24 hours' notice**) so we have the opportunity to offer your appointment to another patient. If less than 24 hours' notice is given, you will be charged a **\$55.00 cancellation fee**. \_\_\_\_\_

(Initials)

If you are a **no show** for a scheduled appointment, you will be charged a **\$55.00 no show fee**. \_\_\_\_\_

(Initials)

### Chiropractic Late Arrivals:

If you arrive late to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.

I understand the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

### Massage Cancellation and No Show Policy:

If you need to cancel or reschedule a Massage Therapy appointment, please call us ASAP (at least 24 hours' notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours' notice is given, you will be charged a **\$55.00 cancellation fee**.

If you do not show for a scheduled appointment, you will be charged a **\$55.00 no show fee**.

### Massage Late Arrivals:

If you arrive late to your appointment, you can pay the full fee and get the time that is left of your session, or you can pay the cancellation fee, and re-schedule for another day.

**The fee will be collected on a voluntary basis.**

By my signature below, I fully understand the above statements and I agree to follow this policy. {If the patient is under the age of 18, I, as the parent or guardian of the patient, understand the above statements and I agree to follow this policy for my dependent (i.e. the minor who is the patient).}

**Print Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent's Signature (if patient is a minor): \_\_\_\_\_