

ELLAD Preventative Health, LLC
Phone: 804-616-4378 FAX: (804) 451-4586

Effective date: _____

No Show/Cancellation Policy

Once an appointment is scheduled, you are provide 24 hours advanced notice of cancellation If 24 hour notice is not provided, **a \$50 no show fee will be charged to your Visa/Mastercard..**

PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF VISA/MASTERCARD HOLDER_____

NAME OF BANK _____

ACCOUNT NUMBER_____ **EXP. DATE**_____

Leave notice of cancellations on office voice mail at **804-616-4378** or via e-mail at **info@elladpreventativehealth.com.**

Your signature below indicates that you have read this policy and agree to its terms.

Patient:_____ Date: _____

Parent, guardian, or representative:_____ Date: _____

Witness: _____ Date: _____