Appointment Cancellation Policy — Patient Acknowledgment

I have read and understand the Advanced Family Medicine Appointment Cancellation & No-Show Policy. I understand that I must give at least 24 hours' notice to cancel or reschedule, and I agree to pay the applicable fee ($60.00 standard visit; $75.00 extended visit or procedure) if I miss an appointment or cancel late, unless the fee is waived or I am a Washington Apple Health client.

Patient name: _____ Date of birth: _____

Signature (patient or legal representative): _____ Date: _____

If signed by a representative, relationship: _____