Anwan Regenerative Center Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Late Arrivals

If patient arrives more than 15 minutes late to the office for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment. When a patient arrives late it disrupts the schedule of the provider

Cancellation Policy

With cancellations made less than 24 hour notice, we are unable to offer that slot to other patients. Office appointments which are cancelled with less than 24 hours notification will be subject to a $50.00 cancellation fee. Procedure cancellations require 48 hour advance notice, without notification they may be subject to a $150.00 cancellation fee.

(Specialty Services – Laser Department, Massage Therapy, IV Therapy)

Appointments cancelled or rescheduled with less than 24 hours notification will be subject to a $25.00 cancellation fee. If it is your first time cancelling or rescheduling with our office, there will be no charge. Any future last minute cancelations or missed appointments will be assessed a fee of $25.00

No Call No Show

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as NO SHOW, with a fee of $25.00. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

(Specialty Services – Laser Department, Massage Therapy, IV Therapy)

Any ***GROUPON*** purchase that has a NO CALL NO SHOW occur, the patient will forfeit their remaining services and or packages.

**All Patients must agree to leave a credit card on file to process all installment payments, cancellation fees, and other orders.

Card Number: ____

Exp Date: _____________ **CVV**: _____________ **Billing Zip code**: _________________

Name on Card: ____

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand, and agree to this Cancellation and No show Policy.

______________________________ ______________________________

Patient Name (Please Print) **Date**

______________________________ ______________________________

Staff Signature **Date**