# EVOLUTIONARY HEALING INSTITUTE

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## CANCELLATION POLICY

**PATIENT NAME:** _____ **DATE:** _____

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance of 24 hours prior to your scheduled time, so we have the option of offering that appointment to another patient.

Please let this letter serve to notify you that if you fail to give 24 hours notice there will be a charge of $50.00 cancellation fee.

Thank you for your understanding,

Dr. Paul Canali, DC

_____

Patient signature

**Please save this form and email to ehmiami@gmail.com**

You will be asked to sign at the office.