

# **DR. PATRICK BARNETT DC**

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## **Cancellation/No Show Policy**

I \_\_\_\_\_ authorize Dr. Patrick Barnett's office to charge me \$50 if I do not cancel my appointment before 10am the previous day or to charge me the full amount of my appointment in case of no show or same day cancellation.

Credit Card # \_\_\_\_\_ Exp \_\_\_\_\_ CVV \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_