**HEALTHY LYMPHATICS OF NC, PC**

**Phone: 828-355-9584**

**Fax: 828-355-9689**

**Healthy Lymphatics-Boone office Healthy Lymphatics-Elkin office Healthy Lymphatics-Mt. Airy office**

**450 New Market Blvd Ste 3 2015 North Bridge St 905 Rockford St**

**Boone, NC 28607 Elkin, NC 28621 Mount Airy, NC 27030**

**Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

**1912 West Park Drive 812 West Stuart Drive**

**North Wilkesboro, NC 28659 Galax, VA 24333**

**UNTIMELY CANCELLATION/NO SHOW POLICY**

Please be aware that HEALTHY LYMPHATICS OF NC, PC has an Untimely Cancellation/No Show Policy, with changes

effective January 1, 2011. Missed appointments have an impact on the therapist’s schedule and are not in the

best interest of you, the patient. We value our patients and strive to provide exceptional care to all those seeking

our services.

Out of consideration for your therapist’s time and patients on a waiting list, we ask that you notify us 24 hours

in advance should you need to cancel or reschedule your appointment. Failure to give at least 24-hour notice of

cancellation of an appointment for each scheduled appointment will result in a charge of $30.00, payable at your

next appointment. THIS CHARGE CANNOT BE BILLED TO YOUR INSURANCE COMPANY AND IS OWED BY YOU.

Should you arrive for your appointment without payment ability your appointment will be documented as an

“untimely cancellation” and you will be assessed the $30.00 fee payable at your next appointment.

Two (2) consecutive “untimely cancellation” or “no shows” or four (4) within four (4) months may result in

termination of your treatment with your therapist.

By signing below, I acknowledge that I have read and understand the Untimely Cancellation/No Show Policy of

HEALTHY LYMPHATICS OF NC, PC. I have received a copy of these terms and agree to abide by them as part of

my consent and agreement for services with HEALTHY LYMPHATICS OF NC, PC.

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**PATIENT PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE**