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Cancellation/No Show Policy

1. Please note we make every effort possible to remind you of your appointments with reminder texts/cards. If you are unable to make an appointment **24 hours advance notice must** be given. Please try whenever possible to cancel an appointment greater than 24 hours in advance if you are unable to attend. This gives us the opportunity to offer the appointment to another patient who needs medical attention. We understand emergencies may arise, we will take this into consideration for certain circumstances. Discretion will be left to the office manager and owner in all cancellation and no show circumstances. If 24 hours' notice isn't given a \$25 fee will be assessed to your card on file. If the card is declined, you will be responsible to pay the fee before scheduling your next appointment.
2. **No call/No shows** will be charged for the full amount of the scheduled service missed. The No Call/No Show fee will be charged to your card on file. If the card is declined, you will be responsible to pay the fee before scheduling your next appointment. Please note that all credit card numbers on file are stored in a secured PCI complaint terminal.
3. **Running Late:** We pride ourselves on taking your time seriously and hope you will do the same for us. If you are running more than 10 minutes late, you have the option of waiting to see if any other patients cancel or do not show, or you can reschedule your appointment for the next available time. However, you will still be charged a \$25 cancellation fee.

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Please Read Completely:

I, _____ understand that my Chiropractor and/or massage therapist's time is valuable. I will make every effort to give 24 hour advance notice if I need to cancel my scheduled appointment. I agree, permit and authorize Peak Performance Chiropractic & Wellness the right to charge my credit card \$25 and I agree to pay for appointments not canceled 24 hours in advance.

I, _____ also agree, permit and authorize Peak Performance Chiropractic & Wellness the right to charge \$34 for a Chiropractic appointment or the full amount of my schedule massage service if I no call no show.

I, _____ have read fully, understand and agree to the above.

Credit Card Authorization Form

Name as appears on credit card: _____

Billing Address: _____

Credit Card Type: ___Visa ___MasterCard ___Discover ___AmEx

Credit Card Number: _____

Expiration Date: _____

Card identification Number/CVC#: _____ (3 digits on the back of the card)

Print Patient Name: _____

Guardian Name: _____

Patient or Guardian's Signature: _____

Date: _____