Adrianne M. Balsam, M.D.S.C

Cancellation Policy

I, _____, hereby agree to give Dr. Adrienne Balsam 24 hour notice of any necessary appointment cancellation. In the event I am unable to provide 24 hour notice off cancellation I hereby agree to pay 100% of the scheduled appointment fee and I hereby give permission to bill my credit card for the missed appointment time.

Payment Policy

I, _____, herby agree to give permission to Dr. Adrienne Balsam to bill my credit card for any outstanding bill more than 45 days overdue plus a 3% processing fee.

Credit Card #: _____

Expiration: _____ CVV: _____

Card Name: (circle one) VISA MC AMEX

Cardholder's name: _____

Cardholder's signature: _____

Dr. Balsam is sensitive to the fact that personal and family emergencies do occur. She reserves the sole authority to make exceptions to these policies.