Eye Center South

Dr. Bryant No Show/Cancellation Patient Acknowledgment

I have been given a copy of Eye Center South's Notice of Cancellation/No Show fees. I understand that I will be responsible for paying the $50 fee for clinical appointments or $250 fee for surgical appointments not cancelled or rescheduled 24hrs prior to the scheduled arrival time.

_____	_____
Signature of Patient	Date
_____	_____
Printed Name of Patient Legal Guardian/Representative	Signature of Parent or
_____	_____
Medical Record Number	Printed Name of Parent or Legal Guardian/Representative