**DAVID A. STEENBLOCK, M.S., D.O., INC.**
**PERSONALIZED REGENERATIVE MEDICINE**
**187 AVENIDA LA PATA**
**SAN CLEMENTE, CA 92673**
**PHONE (949) 367-8870**
**FAX (949) 367-9779**

## NO-SHOW PAYMENT POLICY

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINTMENTS

Please understand that when an appointment is scheduled for you, a time is set aside and reserved for you on the master schedule. Failure to cancel without appropriate notice prevents us from filling the vacancies in our schedule and often prevents people in need from receiving desired services in a timely manner. Therefore,

**I understand and agree to the following:**

1. It is my responsibility to notify

   **David A. Steenblock, D.O., Inc.**
   **At (949) 367-8870**

   24 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

2. I agree that I will be billed 50% the scheduled services in the event that I miss an appointment and fail to cancel 24 hours prior to the scheduled appointment.

Patient Signature________________________ Printed Name____________________________

Practitioner Signature____________________ Printed Name David A. Steenblock, D.O., Inc

Date________________________________________________________________