

Patrick Lau, M.D.

Steve Hwang, D.O.

Kari Hazzard, P.A.C

Rupinderjit Samra, F.N.P

2410 Del Paso Rd. Sacramento, CA 95834

Office: (916) 928-0856 Fax: (916) 928-1584

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## No-Show/Late Cancellation Policy

I, \_\_\_\_\_, have been made aware  
**(patient name, if minor then parents name)**

that as of July 1<sup>st</sup> 2014, there will be a No-Show/Late Cancellation Policy in effect. I understand that I must give the office notice of appointment cancellation at least 24 hours prior to my scheduled appointment time. If I fail to give 24 hours notice, I understand that I will be charged a fee of \$25.

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Patient/Parent Signature

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Date