Victor E. Mendoza M.D.
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Patient Cancellation Policy Consent

I ________________________________, agree to notify Fountain of Youth Medical Spa of any appointment cancellation 24 hours in advance, or I will be subject to a $25 fee upon my next visit. I understand that upon any no show, I will not be seen for any future appointments unless I pay my $25 fee beforehand.

________________________________ ________________

Patient Name (Printed) Date

________________________________ ________________

Patient Signature Date

________________________________ ________________

Witness/Clinician/Physician Signature Date