Cancellation Policy

KEVIN M. FORD, M.D. KAREN L. BLEDSOE, M.D.

Patient Name: _____

Identification # _____

I understand that as a patient of this practice, it is my responsibility to notify Ford Medical Associates if I am unable to keep my scheduled appointment. Cancellation of my appointment in a timely manner allows other patients an opportunity to get same day service or an earlier appointment. If a cancellation is not made within twenty-four hours of a scheduled appointment, a $35.00 (thirty-five dollar) fee ***may be applied*** and will be due before my next visit. My signature on this document verifies that I acknowledge, understand, and agree to comply with office policy, and that any questions regarding this policy have been answered.

_____ _____

Signature of Patient Signature of Witness

_____ _____

Date Signed Date Signed