Jennifer M. Serrentino, M.D.

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414 Main Street
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Cancellation Agreement

Please initial each statement and sign at the bottom.

The patient understands that if they do not show for an appointment without calling to cancel they will be responsible for payment of the full session fee._____

The patient understands that if an appointment is not canceled within twenty-four hours of the appointment time that they will be responsible for payment of the full session fee._____

The patient understands that I will try my best to start all sessions on time. If for whatever reason that is not possible, I agree to spend the full scheduled session time with you. If that is not possible because of scheduling constraints by you or me, we will discuss how to make up the time in a way that is convenient for you._____

_____ _____
Jennifer Serrentino, MD Date

_____ _____
Patient Signature/Printed Name Date