

Cancellation Policy

ANGELA BULLY, M.D.

TAMMIE L. BULLY, M.D.

Patient Name: _____

Identification # _____

I understand that as a patient of this practice, it is my responsibility to notify Dr. Bully's office 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 \$25.00 (twenty-five dollar) fee *may be applied* and will be due before my next visit. My signature on this document verifies that I understand and agree to comply with this policy, and that any questions regarding this policy have been answered.

Signature of Patient

Signature of Witness

Date Signed

Date Signed