

**DAVID A. STEENBLOCK, M.S., D.O., INC.
PERSONALIZED REGENERATIVE MEDICINE
26381 CROWN VALLEY PKWY, SUITE 130
MISSION VIEJO, CA 92691
PHONE (949) 367-8870
FAX (949) 367-9779**

NO-SHOW PAYMENT POLICY

**DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED
APPOINTMENTS**

Please understand that when an appointment is scheduled for you, a time is set aside and reserved for you on the master schedule. Failure to cancel without appropriate notice prevents us from filling the vacancies in our schedule and often prevents people in need from receiving desired services in a timely manner. Therefore,

I understand and agree to the following:

1. It is my responsibility to notify

**David A. Steenblock, D.O., Inc.
At (949) 367-8870**

24 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

2. I agree that I will be billed 50% the scheduled services in the event that I miss an appointment and fail to cancel 24 hours prior to the scheduled appointment.

Patient Signature _____ Printed Name _____

Practitioner Signature _____ Printed Name David A. Steenblock, D.O., Inc

Date _____