NOTIFICATION OF LATE CANCELLATION/FAIL POLICY

I UNDERSTAND THAT BY SIGNING BELOW, THAT I HAVE BEEN INFORMED OF IROQUOIS MENTAL HEALTH CENTER'S $50 (FIFTY DOLLAR) LATE CANCELLATION/FAIL FEE.

I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION.

____
Print Client Name   Date of Birth

____
Print Parent or Guardian Name (of applicable)

____
Client Signature   Date of Signature

____
Parent/Guardian Signature Date

____
Witness Signature   Date of Signature