WEST UNIVERSITY Wellness

5107 Bellaire Blvd.
Suite 210
Bellaire, Texas 77401
713-490-2225 (phone)
713-490-2226 (fax)
www.westuwellness.com

Cancellation Policy & Automatic Debit Form
Below is our cancellation policy. Please read and sign below.
For your convenience, we can automatically charge your credit or debit card for services provided.
If you would like our office to securely store your card for automatic payment, please authorize below.

PATIENT LAST NAME:	PATIENT FIRST NAME:		
Address	City	State	Zip
Phone Number	Email		

Our office has a 24-hour cancellation policy. If you do not call to cancel or reschedule your appointment (scheduled by you or your authorized representative), more than 24 hours in advance of your scheduled appointment, you will be assessed a cancellation fee. You may notify us by phone, e-mail, or text if you are cancelling or rescheduling. You can leave a message even on weekends or afterhours as your message will be time-stamped.

Cancellation Policy

If you do not call to cancel or reschedule your appointment more than 24 hours in advance, for any reason, you will be assessed the following cancellation fee:

- $10.00 –Therapies
- $20.00 – Adjustments & Therapies
- $30.00 – Office Visits
- $30.00 – Manual Therapy by Doctor
- $30.00 – 15 minutes Craniosacral
- $50.00 – 30 minutes Craniosacral
- $80.00 – New Patient Appointments
- $1.00 per minute for scheduled services- Massage & other timed services

Late Policy

If you are late for a massage or exercise session, you might not be able to get your full scheduled time. You will, however, be charged the full rate of your original scheduled service.

- 30 minutes- $30.00
- 45 minutes- $45.00
- 60 minutes- $60.00
- 90 minutes- $120.00

Please let us know in advance if you have any contraindications to massage such as, but not limited to, contagious illnesses or rashes.

A cancellation fee will be accessed for appointments transferred without 24-hour prior consent issued by our office.

I acknowledge that I have read and will adhere to the cancellation policies. I understand that my credit card will be charged if I do not cancel or reschedule my appointment 24 hours in advance and I will not dispute the charge.

X _____ _____
Signature (legible) Date

TERMS: I hereby authorize an automatic debit on the account designated on this form in payment for any products, services, cancellation or other fees provided by West University Wellness, PC. This authorization with the terms stated herein shall remain in effect until West University Wellness, PC receives written notification from me. (Please give at least a30-day notice so records are updated correctly.) I represent and agree that I am authorized to execute this transaction.

Signature of Patient/Guardian (legible) X	PRINTED Account Holder Name	Date
Signature of Witness	PRINTED Witness Name	Date