[Nutritious Dish with Kyle RDN]
[Kyle Parker RDN
[kylejp58@gmail.com
734-341-0188

Effective date: _______________

No Show/Cancellation Policy (uninsured)

Once an appointment is scheduled, you are expected to pay out of pocket for the full-established fee, unless you provide 24 hours advanced notice of cancellation.

Leave notice of cancellations on my voice mail at [phone number] or via e-mail at [contact e-mail address].

Your signature below indicates that you have read this policy and agree to its terms.

Patient:____ Date: ___________

Parent, guardian, or representative:__________________________ Date: ___________

Witness: ____ Date: ___________