Sovereign Women's Healthcare
Sabrina D. Harrison, M.D., P.C.

Ultrasound No Show/ Cancellation Policy

Patient is required to provide us with a **24 hour notice** if there is a need to cancel your scheduled Ultrasound appointment. Please make note of your appointment day/time.

You are scheduled for an Ultrasound in our office on _____

at _____.

Please remember that you are required to notify our office 24 hours in advance if you must cancel your scheduled ultrasound appointment.

If you fail to provide us with a **24 hour** cancellation notice, you will be **charged** a no show/ cancellation fee in the amount of **$100** for the pre-scheduled ultrasound appointment. This is in order to cover the cost of the ultrasound technician.

Patient signature:_____Date: _____

Print name: _____