

# North Coast Family Foundation

---

- I have read and received a copy of the Financial Policy for North Coast Family Foundation.
- **I am aware that I will be charged \$50 if I do NOT cancel my appointment at least 24 hours in advance.**
- I have received a copy of the Practice Privacy Statement.
- I have read and signed the Privacy Consent Form.

---

Patient's Signature

---

Date

---

Patient's Name (printed)