



Other Fees Acknowledgment

Date: _____

Office Visits:

As a patient of Orlando Foot and Ankle Clinic, I acknowledge that I ***may*** be charged a \$10 fee should I “no show” and/or do not cancel my appointment within 24 hours of the appointment.

MRI Scan & Pin Point Laser Procedure:

As a patient of Orlando Foot and Ankle Clinic, I acknowledge that I ***will*** be charged a \$50 fee should I be scheduled for these types of procedures and I “no show” and/or do not cancel my appointment within 24 hours of the appointment.

Sign Language Services:

As a patient of Orlando Foot and Ankle Clinic, I acknowledge that I ***will*** be charged a \$90 fee should I request an interpreter and I “no show” and/or do not cancel my appointment within 24 hours of the appointment.

Completion of Forms:

As a patient of Orlando Foot and Ankle Clinic, I acknowledge that I ***will*** be charged a \$20 fee for completion of a simple form and a \$40 fee for completion of a complex form.

Patient Signature

Print Patient Name