**Alancia C. Wynn, MD**
**8316 Arlington blvd., #234**
**Fairfax VA 22031**
**(ph)703-560-0300 (fax)703-560-8679**

*Date:*_____

# ADVANCED BENEFICIARY NOTICE:

*I understand that in certain circumstances my insurance may decide that appropriate medical services are not covered or necessary. Since they may decide to deny payment for services such as EKG's, Flu shots and other vaccinations, certain lab tests (including, but not limited to PSA, Pap smears, etc), I agree to be personally responsible for payment of these charges.*

# MISSED APPOINTMENTS & LAST MINUTE CANCELLATIONS

*I understand that MISSED APPOINTMENTS (no shows), and/or LAST MINUTE CANCELLATIONS (appointments not canceled at least 24 hours prior), will incur a fee that is the responsibility of the patient.*

*Initials:*_____ *Name:*_____ *Signature:*_____