



Cancellation and No Show Policy

Dear Patient:

We strive to meet and exceed the expectations of all our patients and we are dedicated to rendering excellent medical care to you and the rest of our patients. In order to meet your needs we are implementing a cancellation and no-show policy. This policy enables us to better utilize available appointments for our patients.

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide at a minimum 48 hours' notice.

Time is specifically reserved for you on the physician's schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to the clinic during your assigned time. This results in patients not getting the care they need, when they need it.

As a courtesy, we contact you seven business days and two business days prior to your appointment to remind you of your appointment

Office appointments which are cancelled with less than 48 hours notification may be subject to a **\$50.00** cancellation fee. Cancellation less than 48 hours will be reviewed on a case by case basis.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW**. Patients who no-show two (2) or more times in a 12 month period, may be dismissed from the practice and denied any future appointments. Patient may also be subject to a **\$50.00** fee for not showing to an appointment.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY AND ARE THE SOLE RESPONSIBILITY OF THE PATIENT AND MUST BE PAID IN FULL BEFORE THE NEXT APPOINTMENT.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Your health is important to us.

Please sign that you have read and understand this Cancellation and No Show Policy.

Patient Name (Please Print)

Date of Birth

Signature of Patient or Patient Representative

Date Signed