



Patient No-show, Cancellation and Re-scheduling Policy

No-shows:

Defined as a patient who does not arrive for their scheduled office visit, telemedicine visit, or procedure.

“No-show” appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient does not show up for a scheduled appointment it:

- Potentially jeopardizes the health of the “no-showing” patient.
- Displaces the care of another patient that would have taken the appointment slot.

- A patient who does not show for their office/telemedicine visit appointment **will be charged \$50.00 per occurrence.**
- A patient who does not arrive for their scheduled procedure **will be charged \$100.00 per occurrence.**
- These fees will be charged to the patient and not the insurance company, and are **due at the time of the patient's next office visit.**
- A patient who repeatedly does not show for their office/telemedicine visit appointment or scheduled procedure could lead to the patient’s dismissal from the practice.

Cancellations and Rescheduling:

Defined as a patient who does not cancel their scheduled office visit, tele visit, or procedure in a timely manner.

- A patient who cancels an appointment without providing two (2) business days’ notice **will be charged \$50.00 per occurrence.**
- A patient who cancels a scheduled procedure without providing four (4) business days’ notice **will be charged \$100.00 per occurrence.**
- A patient who re-schedules an appointment more than two (2) times after the initial scheduled appointment **will be assessed a fee of \$50.** Repeated requests to re-schedule appointments and procedures could lead to the patient’s dismissal from the practice.

Cancellation and rescheduling fees will be charged to the patient and not the insurance company and are due at the time of the patient's next office visit.

I have read and understand the No-show, Cancellation and Rescheduling Policy and agree to its terms.

_____	_____
Signature (Patient/legal Guardian)	Relationship to Patient
_____	_____
Printed Name	Date