Account # ____________

Date ____________

No Show/Late Cancellation Policy

Patient's name: ______________________ Date of Birth: ____________

Patient's name: ______________________ Date of Birth: ____________

Patient's name: ______________________ Date of Birth: ____________

Patient's name: ______________________ Date of Birth: ____________

We value your child/children as a patient in our practice and strive to provide him/her with the best possible care. In order to do this, we need your cooperation in keeping your child/children's scheduled appointments. When an appointment is missed without prior or ample notification, their appointment slot cannot then be offered to another patient who needs to be seen. Failure to keep scheduled appointments also prevent us from providing your child/children with comprehensive healthcare and from fully establishing the patient/physician relationship necessary for continuity of care. We make reminder calls but ultimately it is a courtesy and is your responsibility to remember any appointments.

With this in mind, effective immediately, your account will be charged a $25 no show/late cancelation fee for a missed appointment without at least 24 hours prior notice, including same day appointments. We ask for a minimum 24 hours' notice so that we may then offer that appointment slot to another child/children.

Cancelation and no-show fees are the sole responsibility of the patient (Parent) (they are not covered by your insurance) and must be paid in full prior to your next appointment.

We also reserve the right to consider dismissing your child/children from the practice if two or more missed appointments without ample notification occur.

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Responsible Party Signature

______________________ ____________

Responsible Party (Print) Relationship