# Petition to Waive Missed Appointment Fee

**Overview:**

Missed appointments are a costly expense for a small business such as ours and a missed opportunity for a patient to receive crucial health care. **Although we provide patient reminder phone calls and/or emails as a courtesy, ultimately each patient and their caregivers are responsible for ensuring the patient is scheduled properly and shows up for the appointment as agreed to in the new patient paperwork.**

We know you are busy and we value your time just as we ask that you value ours when we set the policy that you provide a minimum of 48 hours notice to cancel your appointment and by honoring to pay the missed appointment charge in the event you missed an appointment without the notice. Understand that this charge is a small fraction of the typical reimbursement our office receives for a medical encounter and has been established as a "gentle reminder" of your obligation to provide advance notice of missed appointments. If a large enough number of patients do not show up for their scheduled appointments, even if they honor the missed appointment fee, we would not be able to continue to stay in business.

**Print Patient Name:** _____

**Date/Time of Missed Appointment:** _____

We expect everyone to plan appropriately, keep track of their calendar appointments and leave early enough to get to the appointment on time. Please help us evaluate your circumstance to determine whether a waiver is appropriate in your circumstance. Note the fees may only be waived on patient accounts with balances.

Extenuating circumstances (please check and complete all of these that apply)

- ___Patient admitted to the following hospital/ER:_____

  Admission Date/Time:_____ Discharge Date/Time:_____
- ___Patient is a long standing patient since _____ (month/year) and has never missed an appointment until the appointment on _____ (date and time)
- ___Patient called to cancel/reschedule MORE THAN 48 hours prior to the appointment.

  Appointment Date/Time:_____

  Call Date/Time:_____ Spoke with:_____
- ___Other:_____

I request the missed appointment fee of $_____ be waived due to the above circumstances and understand my obligation to pay all balances not covered by insurance including any missed appointment fees should the practice decline my petition. All outstanding balances must be paid prior to considering any fee waivers.

_____ _____

Patient Signature [or caregiver] Date

**[Official use below. Note: decisions may take up to 10 business days upon receipt of petition.]**

DECISION (APPROVED OR DECLINED):_____

_____ _____

FCN Signature Date