



**Joan F. Bailey, M.D.**

2200 N. 3<sup>rd</sup> Street  
Phoenix, AZ 85004  
Phone: 602-258-9955 Fax: 602-258-9933

### **No Show / Cancel Appointment Agreement**

As a patient or guardian for a patient receiving services from Midtown Endocrine Associates, I understand that I am responsible to cancel appointments within appropriate timeframes. I do hereby agree to the following:

1. I will cancel a scheduled appointment at least 24 hours before the appointment.
2. I agree to pay a \$100.00 for new patient and \$50.00 established patient appointment fee when I fail to cancel my appointment without 24 hour notice before the appointment.
3. Allowances will be made for failing to keep my appointment due to unavoidable or reasonably unforeseen circumstances.
4. The medical professionals at Midtown Endocrine Associates may terminate my services if I do not cancel or fail to attend three scheduled appointments.
5. Should Midtown Endocrine Associates terminate my services, they will send me a "termination of services" letter. This letter will explain that a 30-day grace period will be given to enable me to secure alternative services, and will also allow prescription refills when medically appropriate for 30 days from the date of the "termination of services" letter.

\_\_\_\_\_  
Patient / Guardian Signature

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Date