Dr. Mark H. Schecker
Allergist

Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Coastal Carolina Allergy and Asthma
"No Show" and "Cancellation" Policy and Procedure for Office Visits and Procedures

At Coastal Carolina Allergy and Asthma our goal is to provide quality allergy, asthma, and immunology care in a timely manner. We have implemented a no show and cancellation policy that enables us to better utilize available appointments for other patients in need of care. These appointments are in high demand. Recognizing that everyone's time is valuable, we ask that you provide at least a **24-hour notice** if you are unable to keep your appointment. Patients will be notified of this policy at the time of scheduling. It will be available on our website www.myrtlebeachallergist.com for review and can be provided in writing upon request.

Effective July 1, 2021, the policy regarding patients who do not notify us as outlined or fail to keep their scheduled office visit appointments (i.e., no-show) is as follows:

- For missed initial consultation appointments, there is a **$100 fee**.
- For all other missed appointments, there is a **$50 fee**.
- These fees will be charged to the patient, ***not their insurance company***, and is due at the time of the next appointment.
- Patients with an outstanding balance of missed appointment fees ***will not be allowed to schedule another appointment, including allergy shots, until this balance is paid in full***.
- Multiple no show appointments will result in ***dismissal from the practice***.

Please be courteous and cancel your appointments in a timely fashion, by calling (843) 293-0093. You may leave a message if there is no one in the office. We understand that emergencies and unforeseen events can occur and depending on the circumstances the missed appointment charge may be waived.

Thank you for your cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

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Patient Signature (Parent/Guardian if under 18)

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