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NO-SHOW, CANCELLATION AND COLLECTIONS POLICY

Name _____ **Date** _____ **Patient Account #** _____
(Please Print) **(Office Use Only)**

Failure to appear for your scheduled appointment, failure to provide adequate notice to cancel a scheduled appointment (24-hours in advance during normal business hours), or failure to provide payment for co-pays, co-insurance or deductibles may result in charges as outlined below. A valid credit card must remain on file and will be charged appropriately. A copy of the credit card receipt and a written explanation of charges will be mailed to the address on file.

24-HOUR NOTICE REQUIREMENT – PLEASE READ

Notification of the need to cancel an appointment must be made at least 24 hours in advance of a scheduled appointment. **Notification can only be made during normal business hours (Monday through Friday from 9:00 a.m.to 4:30 p.m.).** Cancellations made during evening hours, Saturday, Sunday or Holidays are not considered normal business hours and a cancellation fee may apply.

Example:
Cancellation for a Monday appointment must be made by close of business the Friday prior.

Name on Credit Card _____ **Exp. Date** _____
Credit Card # _____ **3 or 4 Digit Code** _____
Cardholder Signature _____
Patient Signature* _____ **Date** _____
Legal Guardian Name** _____
Legal Guardian Signature** _____ **Date** _____

ALL APPOINTMENT TYPES

A charge of $50.00 per missed appointment will apply to patient accounts for appointments scheduled with any clinical staff member if:

- Patient fails to show up for a scheduled appointment.
- Patient fails to provide 24-hour advance notice for cancellation.

COLLECTIONS:

- All balances (including co-pays, co-insurance and deductibles) are due at the time of the visit. You will be notified in writing, and provided a copy of your receipt, when charges have been made to your credit card.
- Any remaining balance on your account that is not paid within 90 days will be turned over to a collection agency. If needed, you may contact our billing office for payment arrangements.
- There will be a $10.00 charge if your co-pay is not paid at the time of service.

I have read and understand the no-show, cancellation and collections policy and agree to be bound by its terms.

Patient Signature* _____ **Date** _____

*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.