Matthew A. Berger, MD, PC

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NO-SHOW AND CANCELLATION POLICY

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

Failure to appear for your scheduled appointment or failure to provide adequate notice to cancel a scheduled appointment (24-hours in advance), may result in the following fees. A valid credit card must remain on file and will be charged appropriately.

MEDICATION MANAGEMENT APPOINTMENTS:

A charge of $50.00 for new patient appointment/$30.00 for follow-up appointment will apply to patient accounts for appointments scheduled with Dr. Berger,
Dr. Mallik, Dr. Nardell or any clinical staff member if:

- Patient does not show up for their scheduled appointment.
- Patient fails to provide 24-hour advance notice for a cancellation.

THERAPY APPOINTMENTS:

A charge of $40.00 will apply to patient accounts for appointments scheduled with any Therapist if:

- Patient does not show up for their scheduled appointment.
- Patient fails to provide 24-hour advance notice for a cancellation.

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

Patient Signature* _____ **Date** _____

_____ **I agree for my credit card to be charged.**
(Please complete the information below and sign the Patient Signature line.

_____ **I disagree for my credit card to be charged.**

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** _____

*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.