CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Jacksonville Kids Pediatrics is to provide you and your child with convenient, accessible, high quality medical care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive timely for all scheduled appointments or cancel the appointment **24 hours in advance**. This policy allows us to make better use of our available appointments for those patients in need of medical care.

Cancellation of an Appointment

You may cancel your scheduled appointment by calling our office during regular business hours. Appointments are in high demand and your early cancellation will give another child the opportunity to be seen by a provider.

No Show Policy

A "No Show" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, we will record this in the medical record as a "No Show".

Each time you miss your appointment, you will be notified by telephone and you will be asked to re-schedule.

Fees for Appointments – Financial Agreement

Effective February 10, 2020, Jacksonville Kids Pediatrics will begin to charge patients when they do not present for scheduled appointments.

Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for a missed appointment. This fee will not be submitted to the health plan; it will be charged to the patient. We understand that flexibility is important and patients may be allowed one "free" missed appointment charge.

The missed appointment fee structure:

$25 for the following types of appointments; Sick Exams, follow up appointments

$50 for the following types of appointments; Well visits, ADHD appointments, Pre-Op appointments

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I understand that I will be billed for the applicable fee and I am responsible for paying the fee. I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments.

Please note: Four (4) "NO SHOW appointments" may result in discharge from the practice.

Signed ______________________________ **Date**______________

Child's Name __________________________ **Child DOB** ______________