Clinical Pediatric Associates of North Texas
Specializing in Infants, Children and Adolescents

Occasionally, we all miss an appointment. However, repeated missed appointments are unacceptable, and results in delayed care for other patients. Our goal is to accommodate patients in a timely manner. In order to do so, we are implementing the following no show/cancellation/reschedule policy, effective 11/1/2017.

Parent/Guardian Name (Please print): _____

Please list names and birthdates of all children that are patients of the practice.

_____ D.O.B._____

_____ D.O.B._____

_____ D.O.B._____

_____ D.O.B._____

No Show/Cancellation/Reschedule policy

1. This policy became effective **November 1, 2017**.
2. I will be billed a $50 fee for any no show, missed appointment or any appointment changed or cancelled less than 24 hours prior to the scheduled appointment time, including same day appointments.
3. This fee must paid before a well visit appointment is scheduled.
4. Patients with ***three*** missed appointments in a twelve month period may be asked to transfer their records to another practice.
5. Your child's appointment time will be confirmed via an automated email, phone call or text to the Communication Preference you selected. Please make sure we have your current phone numbers.
6. I am responsible for this fee as my insurance considers this a non-billable event.

I have read and understand the policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature: _____ Date: _____

Elizabeth S. Dickey, MD PhD FAAP Trung D. Tran, MD FAAP Vi Hung Pham, MD

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