

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** & was **updated January 1, 2022**.
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.
 - Some appointment types require longer appointment times [i.e. ADHD (30-60min)/Behavior (30min)/Mental Health (30min)/Concussion (30min)]. The fee billed will be \$50 per 15 minutes of time booked for any no show, missed appointment or any appointment changed or cancelled less than 24 hours prior to the scheduled appointment time.
3. This fee must be 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 confirm 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: _____