McCRIMMON PRIMARY CARE plus

Patient Appointment Cancellation & No-Show Policy Acknowledgment

Patient Name: _____

Date of Birth: _____ **Date:** _____

At our practice, we strive to provide timely, quality care to all patients. Missed appointments and late cancellations prevent us from offering appointment times to other patients in need of care. Please review and acknowledge the following policy regarding missed appointments and cancellations.

Appointment Cancellation Policy

If you are unable to attend your scheduled appointment, we kindly ask that you notify our office at least **12 hours prior** to your appointment time.

- Appointments canceled with less than 12 hours' notice will be considered a **late cancellation** and will incur a **$25.00 fee**.
- Patients who fail to attend their scheduled appointment without notifying the office will be considered a **no show** and will incur a **$50.00 fee**.

These fees are the patient's responsibility and are not billable to insurance.

Patient Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the Appointment Cancellation and No Show Policy. I understand that failure to provide adequate notice or failure to attend my appointment may result in the applicable fee being charged to my account. This agreement shall remain in effect for one (1) year from the date of signature and will apply to all scheduled appointments during that time period.

Patient Signature: _____

Printed Name: _____

Date: _____

If signed by a parent or legal guardian:

Parent/Guardian Name: _____

Relationship to Patient: _____

Signature: _____