Patient Acknowledgement Appointment Cancellation Policy

Dear Patient,

Complete Care Physicians has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office a **24-hour notice** in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient.

2. A “No-Show”, “No-Call” or missed appointment, without proper 24-hour notification, may be assessed a **$50.00 fee**.

This fee is not billable to your insurance and can require a credit card pre-authorization. If you are 10 or more minutes late for your appointment, the appointment may be cancelled and rescheduled at the discretion of the staff. As a courtesy, we will give you a reminder call and/or messages for appointments, 1 week to 24 hours in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect. Repeated missed appointments may result in termination of the physician/patient relationship. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you upon request. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Printed Name of Patient (or responsible party)_____

Signature of Patient _____Date _____