Abide Health Medical APC

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Las Vegas, NV 89117
Phone #: (725) 205-1578 Fax #: (725) 485-3749

Acknowledgment of No Show / Cancellation Policy

No Show / Cancellation Policy

The **Abide Health Medical** requires patients to provide **at least 24 hours' notice** if they need to cancel or reschedule an appointment. If a patient does not show up for a scheduled appointment or fails to cancel within the required timeframe, a **No Show** fee may be charged.

By signing this form, the Patient agrees to the following:

- **Cancellation Notice**: If the Patient cannot attend a scheduled appointment, they agree to notify the Clinic at least **24 hours** before the appointment time. Cancellations may be made by phone, email, or through the clinic's online scheduling system (if applicable).

- **No Show Fee**: If the Patient fails to show up for a scheduled appointment without notifying the Clinic at least 24 hours in advance, the Clinic may charge a **no show fee** of **$50** (or a different amount as specified by your clinic). This fee is not covered by insurance and is the responsibility of the patient.
- **Repeated No Shows**: If the Patient fails to cancel or attend three or more appointments without adequate notice in a 12-month period, the Clinic reserves the right to discontinue providing services to the Patient or place them on a **waitlist** for future appointments.
- **Late Arrivals**: If the Patient arrives more than **15 minutes late** for their scheduled appointment, the Clinic may consider the appointment canceled and charge the **no-show fee**. Late arrivals may also result in a shortened session if the schedule permits.
- **Exceptions**: The Clinic recognizes that emergencies and unforeseen circumstances may arise. Patients are encouraged to contact the Clinic as soon as possible in the event of an emergency or extenuating circumstance that prevents them from attending their scheduled appointment. These situations will be handled on a case-by-case basis.

Acknowledgment of Policies

By signing below, I, the Patient (or Authorized Representative), acknowledge that I have read, understood, and agree to the **Abide Health Medical**'s **No Show / Cancellation Policy**. I understand that failure to adhere to this policy may result in a **no-show fee** and/or consequences related to future appointments.

I also understand that I am responsible for notifying the Clinic in advance if I am unable to attend a scheduled appointment and that providing a **minimum of 24 hours' notice** is required to avoid charges.

Signature of Patient or Authorized Representative: _____

Printed Name of Patient or Authorized Representative: _____**Date**: _____

4. Parent/Guardian Signature (if applicable)

If the Patient is a minor or unable to provide consent, the following section should be completed by the parent or guardian:

Name of Parent/Guardian: _____ **Relationship to Patient**: _____

Signature of Parent/Guardian: _____ **Date**: _____