No-show Policy Form

This practice reserves the right to charge a $25 no show fee to patients who no-show their appointment or do not cancel them timely. We ask that all patients please give us 24 hour notice of cancellation.

This practice reserves the right to dismiss patients following 3 consecutive no-shows as this takes away time we can dedicate to other patients that need our care.

To ensure we do the best job possible keeping you informed about your appointments in a timely manner, we request that you frequently check your contact information we have in our files.

I, (please print) _____, have read and understand the No Show Policy and do agree that if I do not cancel my appointment 24 hours prior to my appointment, or if I do not attend my appointment, I will be charged the $25 fee.

Patient signature: _____

Date: _____