SCOTTSDALE MENTAL HEALTH & WELLNESS INSTITUTE
DR. ROLAND SEGAL, M.D., DFAPA
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Late cancellation/No show policy

Thank you for trusting your medical care to Scottsdale Mental Health and Wellness Institute. When you schedule an appointment with SMHWI we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. This policy will be strictly enforced. This policy is non-negotiable. Please see our Appointment Cancellation/No Show Policy below:

Please initial by each statement

____ Phone reminders are a courtesy only. It is patient responsibility to remember the date and appointment time.

____ Any cancellation with less than 48 hours notice will be considered a late cancellation. There will be no disputes about what constitutes a "valid" reason for cancelling. The time will be measured to the minute (i.e. 47 hours, 59 minutes is less than 48 hours).

____There will be a $50.00 charge for the first no show or late cancellation.

____ The second no show or late cancellation will be charged the full fee.

____ The third no show or late cancellation will be charged the full fee and will result in termination from the practice.

____ Fees will be automatically charged to credit/debit cards if this has been your form of payment in the past. Patients that pay cash or by check must arrange for payments to be made before an appointment will be rescheduled.

____ No-show/late cancel fees cannot be billed to patient's insurance company and must be paid out of pocket.

____ Any new patient who fails to show for their initial visit will not be rescheduled.

Patients who are transferred out of the practice (or who do not agree with this policy) will receive an official letter documenting termination of the physician/patient relationship, a list of other area psychiatrists, and prescriptions for up to 1 months of the last medication regimen prescribed. You will be notified by whatever means that are reasonable and necessary.

My signature below affirms that I agree to the all of the terms of this new policy.

Signature: _____ Date:_____

Print Name: _____

P: 480.508.0882
F: 480.508.0891
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