ADVANCED PACIFIC

NO-SHOW/CANCELATION/RESCHEDULE POLICY

1. No-Show/Cancelation Policy for Doctor Appointments/Office Procedures

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from receiving much-needed medical care. Conversely, the situation may arise where another patient fails to cancel or reschedule, and we are unable to schedule you for a visit due to a seemingly 'full' appointment schedule.

Your appointment card, your doctor's phone call or your phone call requesting an appointment is your appointment confirmation. Reminder calls are ONLY made as a courtesy.

If any appointment is not canceled at least 24 hours in advance, you will be charged a $25 no-show fee PER APPOINTMENT. This includes ALL appointments with any ENT doctors and the audiologist. If you were scheduled to see both an ENT and the audiologist on the same day and failed to cancel within the time frame, you will be charged a $50 fee for missing both appointments. There will also be a $50 fee for any missed office surgeries. This fee is not covered by your insurance company, and you will be responsible for paying it before you are seen by the doctor(s) on your next visit. NO EXCEPTIONS.

2. No-Show/Cancelation/Reschedule Policy for Hospital Procedures

Due to the large block of time needed for surgery, last-minute cancelations can cause problems not only with our office but also with the hospital as well. Again, not canceling a surgery in a timely manner may be preventing another patient from receiving much-needed medical care.

If a surgery is not canceled or rescheduled at least seven business days in advance, you will be charged a $100 fee. This fee is not covered by your insurance company, and you will be responsible for paying it. Payment for this fee MUST be made prior to having another appointment made for surgery.

I have read the above statement and understand and agree with the policy set forth above.

_____

Patient Name (Print)

_____ _____

Patient or Responsible Party Signature Date