NO-SHOW LATE CANCELLATION POLICY

Corpus Christi ENT Sinus & Allergy, PLLC and Advanced Hearing Aid & Diagnostics, LLC cultivate a doctor-patient relationship that is based on trust, focusing on patients as individuals. Our providers and excellent support staff strive to be fair and courteous in all our dealings.

The following policy has been established to help us serve you better. It is necessary for us to make appointments to see our patients as efficiently as possible. No-shows and Late Cancellations cause problems that go beyond any financial impact to our practice. When an appointment is made, it takes an available time slot away from another patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients, some of whom may be quite ill and may unnecessarily delay the delivery of health care. For this reason, we have developed the following No-show/Late Cancellation Policy.

A No-show is defined as missing a scheduled appointment without calling us in advance to cancel the appointment. A Late Cancellation is defined as failing to cancel or reschedule a scheduled appointment by 3:00 P.M. the day before your scheduled appointment. We request that if you need to cancel or reschedule your appointment, you must contact our office no later than 3:00 P.M. the day before your scheduled appointment so that we may offer the appointment time to another patient who needs medical attention.

For each No-show or Late Cancellation, we are charging the nominal fee of $25 to cover for the staff that is on hand to provide your needs, this charge will apply to each appointment that a Late Cancellation or No-show occurs. This office will not submit this charge to your insurance carrier or Medicare, as applicable. These fees are your financial responsibility, and they must be paid prior to making any new appointment. A patient who No-shows three times (3) within a twelve-month period, regardless of whether it is in the same calendar year, is subject to dismissal from the practice.

Please understand that the intent of this policy is to aid us in offering a high standard of care to our patients and that this policy is in place to help us achieve that goal. We pledge to do our part to keep our schedule moving as efficiently as we possibly can. We value you as a patient and appreciate your understanding and cooperation.

I acknowledge that I have read and understand this No-show/Late Cancellation Policy. I further understand that I will incur fees in the event I fail to notify this office before 3:00 P.M. the day before my scheduled appointment or if I fail to show up for my scheduled appointment. Any fees incurred are my responsibility to pay and, in the event, I incur a fee, such fee shall be paid prior to making any new appointment.

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Patient Signature or Legally Responsible Person Print Name