MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Town Center Dermatology. When you schedule an appointment with us we set aside up to one hour (depending on the type of appointment) to provide you with the highest quality care. Should you need to cancel or reschedule an appointment **please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment**. This gives us time to accommodate other patients who may be waiting for an urgent appointment opening. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1, 2021 any established patient who **fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice** will be considered a No Show and charged a **$40.00 fee, or a $75 fee for a missed procedure or surgery appointment**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hour notice **a second time** will be charged a **$75.00 fee**.
- Any **new patient who fails to show for their initial visit will be assessed a $50 fee**.
- The fee is charged to the patient, not the insurance company, and the patient will not be permitted to reschedule or make additional appointments until this fee has been paid.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Town Center Dermatology 24 hours a day, 7 days a week at 636-821-1661. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left on the office voicemail are acceptable.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____ _____

Signature (Parent/Legal Guardian Relationship to Patient) Printed Name Date