NO-SHOW / LATE CANCELLATION POLICY

Hill Country Pain Associates, PA cultivates a doctor-patient relationship that is based on trust, focusing on patients as individuals. Our physicians and our support staff strive to be fair and courteous in all of our dealings.

The following policy has been established to help us serve you better. It is necessary for us to make appointments in order 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 these reasons we have developed the following No-show/Late Cancellation policy:

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 without giving 24 hr notice prior to your scheduled appointment.

We understand that everyone might have an unforeseen event in which you cannot make your appointment with us so we have allotted you one (1) grace appointment each calendar year in which you will not be charged a fee, as described below, for that sudden emergency.

For each subsequent no-show or late cancellation during the same calendar year, we are charging the nominal fee of **$25.00 for an office visit and $50.00 for a scheduled procedure/injection.** This charge will apply to each appointment that a late cancellation or no-show occurs. This fee will not be covered by your insurance company. ***These fees are your financial responsibility and they must be paid prior to making any new appointment.*** A patient who no-shows three (3) times within a twelve (12) month period, regardless whether it is in the same calendar year, is subject to dismissal from the practice.

Finally, we understand that circumstances beyond your control may arise, where adequate notice is not possible. These limited situations will be considered on a case by case basis.

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 cancel or reschedule my appointment 24 hours prior to 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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Print Patient Name	DOB	Date
Patient Signature or Legally Responsible Person If Patient Unable to Sign		Witness