No Show, Late, Cancellation Agreement

Name: ____________________

MR #: ____________________

DOB: ____________________

or Apply Patient Label

Phoenix Children's Medical Group would like to welcome you to our multi-specialty clinics. We are hopeful the following information will make this and future visits run smoothly.

All patients/families will receive an 'arrival time' and an 'appointment time' when they schedule a visit. The 'arrival time' assures you will have time to check-in, complete all of your paperwork and be placed in a room by your scheduled appointment.

Our goal is to accommodate all of our patient's healthcare needs and schedules to the best of our ability. Your time and the provider's time are valuable. We want to assure everyone is given the opportunity to maximize their time during a patient's visit. While some late or cancellations are inevitable, please be advised of our policies related to how these are addressed.

Late for Appointment:

- If a patient is more than 15 minutes late for their appointment, the patient may be asked to reschedule their appointment depending on the day's schedule.

Cancellation/No-show Appointment:

- Patients are asked to provide 24-hour notice in advance of their appointment, or may be subject to a cancellation fee.
- Missed appointments will be clinically reviewed and a letter may be sent to you and your primary care provider indicating the missed appointment and need to reschedule.
- Excessive missed appointments (3 or more) may be subject to a patient's discharge from the Specialty Practice in accordance with applicable State and Federal guidelines.

We will make effort to reach you to confirm your appointments in advance. We ask you provide the best number to reach you.

We take great pride in the care of each patient in our practice. Please help our office assist you on each visit by understanding these policies and signing this sheet. If you have any questions our receptionists or other staff is available to answer your questions.

My signature below indicates that I have read and understand these policies

____ ____________________

Signature of Patient or Legally Authorized Representative ***Date & Time***

____ ____________________

Printed Name of Patient or Legally Authorized Representative ***Relationship to Patient***