Clay Platte Family Medicine
Summit Family and Sports Medicine
Cobblestone Family Medicine Clinic
Barry Pointe Family Care

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for entrusting your medical care to us. When you schedule an appointment at one of our locations, we set aside enough time 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 schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective December 1, 2022, 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 **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hours' notice a **second** time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule without 24-hour notice should occur within a 12-month period, the patient may be **dismissed** from our practice.
- Any new patient who fails to show for their initial visit will be allowed one reschedule, if there is a second No Show, no reschedule will be allowed.
- The fee is charged to the patient, not the insurance company.
- 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 Business Office at 816-842-4440, Option 7, they may be able to waive the No Show fee.

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

_____	_____
Signature (Patient or Parent/Legal Guardian)	Relationship to Patient
_____	_____
Printed Name	Date
_____	_____
Patient MRN	Patient DOB