

**ABSOLUTE FOOT CARE**
a gentle approach to foot care
NO SHOW POLICY

Effective: 03/04/2014

Absolute Foot Care is committed to helping you manage and maintain your foot healthcare needs. When you schedule an appointment with one of our physicians, that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office 24-hours in advance. Providing us with adequate notice will allow us to offer that appointment to another patient who needs to see the physician. ***If your appointment was confirmed, there are no exceptions.***

The following no show and/or late cancellation fees will be assessed:

A **\$50 charge** will be assessed for “no showing” or for failing to give a 24-hour notice of the need to cancel all **routine appointment**. A **\$100 charge or 50% of the fee (whichever is greater)** will be assessed for “no showing” or failing to give a 24-hour notice of the need to cancel all scheduled appointments.

A **\$100 charge** will be assessed for **new patients** “no showing” or failing to give a 24-hour notice of the need to cancel all **new appointments**.

These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before scheduling another appointment with the physician. In order to be scheduled, patients must authorize credit card charges. *

Please select one of the following options:

I authorize Absolute Foot Care to charge my credit card indicated below:

Type of credit card accepted:  

Acct. #: _____ Exp: _____ CVC: _____

I do not have a credit card. I will receive a bill and I understand if I do not pay I will be sent to collections.

I refuse to sign this document and understand I will not be accepted into the practice as a patient and will need to seek care elsewhere.

 x

Patient's Signature

Date