MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to New Hope Psychiatry, LLC. When you schedule an appointment with New Hope, we set aside 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 helps us to be respectful of other patients needs and enables us to give the appointment time to another patient. Please see our Appointment Cancellation/No Show Policy below.

- *Any 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/Late Cancellation.*
- *Any new patient who fails to show for their initial visit will not be rescheduled.*
- *If a second No Show occurs within a 6 month time period, you may not be able to schedule another appointment. At that time, services will be provided on a walk-in basis during specific pre-designated morning times. Those on a walk-in status will be asked to wait in the lobby for an available opening between regularly scheduled appointments.*
- *If a third No Show occurs the patient may be dismissed from our practice.*
- *As a courtesy, when time allows, we make reminder calls for appointments as well as send reminder emails. If you do not receive a reminder message, this Policy remains in effect. Please ensure that we have the correct phone number and email on file so that we can reach you.*
- *Prescription refills are authorized during appointments and therefore, if a patient does not keep their appointment as requested by the treating provider, prescription refills may not be provided until the patient is seen for evaluation. It is important to monitor a patient's progress in treatment throughout the course of care and with your input, your provider will determine how often appointments should occur.*

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 Secretary, who may be able to waive the No Show status.

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

Patient Name _______________________________________ Date _________________

Signed ____ Date _________________