

No -Show Acknowledgement Form

IN AN EFFORT TO BETTER SERVE OUR PATIENTS, WE ARE REQUIRING A 24-HOUR ADVANCE NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

I understand the importance of keeping my scheduled appointment and agree to notify the office at least 24 business hours in advance. I also understand that there could be the potential of a dismissal from the practice if three (3) no -shows occur in any twelve (12) months period.

KEEPING APPOINTMENTS IS IN THE PATIENTS BEST CLINICAL INTEREST.

Patient Name: _____

Patient or Guardians Signature: _____

Date: _____