APPOINTMENT CANCELLATION POLICY **EFFECTIVE 8/1/2016**

Dear Patient:

Thank you for choosing the Diabetes Care Center. Our goal is to see patients at their scheduled appointment time that we have specifically reserved for them. We will make every effort to accommodate a patient's personal schedule and provide a date and time that is convenient to them. We understand that occasionally emergencies, illnesses or last minute situations prevent a patient from keeping a scheduled appointment. When these situations do happen, we kindly ask that you contact our office **at least 24 hours prior** to your appointment date and time to either cancel or re-schedule your appointment.

Effective August 1, 2016, we will be enforcing our appointment cancellation policy fee as stated below. As a courtesy, our office will make an attempt to contact a patient to confirm their appointment two (2) days in advance. We will use the contact information provided by the patient to make such contact or leave a message if possible. It is the patient's responsibility to provide our office with the most current contact information available. We will not be responsible if the information on file is outdated or incorrect. If you do not contact our office at least 24 hours prior to your scheduled appointment, a **non-cancellation fee** will be applied to the patients account.

The fee for a non-cancelled appointment is:

- **New Patient / First Time Visit: $100 per incident. NO EXCEPTIONS!**
- **Existing Patient: $50 per incident**
    - **One (1) courtesy adjustment will be provided per account, per calendar year**
    - **Additional adjustments will not be given once the courtesy adjustment has been applied**

Failure to comply or non-payment of the non-cancellation fee may result in cancellation of future appointments or services. Should you have any questions regarding our appointment cancellation policy, please don't hesitate to call us at (831) 769-9355.

By signing below, you acknowledge that you have received a copy of the Appointment Cancellation Policy and are aware of the associated fees. A signed copy of this policy will be kept in the patient's medical record for future reference.

Date: ______________________

Patient's Name (Printed): ____

Patient's Signature: ____

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