OSTEOPATHIC FAMILY WELLNESS CENTER
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Board Certified in Family Medicine and Osteopathic Manipulative Treatment

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification will be subject to a $85.00 cancellation fee. Procedure cancellations (Osteopathic Treatment) require 3 business day advance notice, without notification they will be subject to a $85.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a NO SHOW. Patients who No-Show two (2) or more times in a 12-month period will be dismissed from the practice thus they will be denied any future appointments.

Established patients are asked to arrive 5 minutes prior to their scheduled appointments. This allows enough time for the registration process to be completed before the actual appointment time. For Osteopathic Treatment appointments a grace period of 5 minutes will be permitted for unforeseen delays. For a regular office appointment there is a grace period of 10 minutes. If a patient arrives past the grace period, the patient will be given the option of either being seen that day by another provider, if the schedule permits, or rescheduled for a later date. This process will ensure patients that do arrive on time are seen in a timely manner.

The Cancellation and No Show fees are the sole responsibility of the patient. Insurance will not cover this fee and must be paid in full before the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

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Patient Name (Please Print) Date of Birth

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Signature of Patient or Patient Representative Date