FAMILY Podiatry and Vein Care

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Appointment Cancellation / No Show Policy

Thank you for trusting Family Podiatry for your care needs. Keeping your appointments helps to make sure your health is at an optimal level. We make every effort to ensure that you receive complete and thorough care at each one of your appointments.

Unfortunately, due to a substantial increase in last minute cancellations and appointment no shows, we have been forced to implement and enforce a "Cancellation / No Show Policy." Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than **One Business Day (weekends Excluded)** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Our Appointment Cancelation / No Show Policy is as follow:

- *Effective June 1, 2025*, any new or established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **One Business Day (weekends Excluded)** notice will be considered a "No Show / Last Minute Cancellation" and will be charge a **$50 fee**.

- This fee is charged to the patient, not the insurance company, and is due before your appointment will be rescheduled.

- If a third "No Show or Cancellation/Reschedule" without at least **One Business Day (weekends Excluded)** notice should occur, an established patient may be dismissed from Family Podiatry care, as we will be unable to provide appropriate ongoing care. A new patient will no longer be rescheduled.

- As a courtesy, we make reminder calls and automatic text messages are sent out for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

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 let us know and this will be kept in mind when reviewing your account.

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

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Today's Date: _____