

## No Show/Late Cancellation Appointment Policy

It is our goal to provide excellent care to each patient in a timely manner. If a patient must cancel their appointment, please contact us by phone, email, or through the patient portal no later than 24 hours before the scheduled appointment. This allows us to open that reserved time to other patients in need of prompt medical care. "No Show" means any patient who fails to arrive for their scheduled appointment. "Late Cancellation" means any patient who cancels an appointment less than 24 hours before their scheduled appointment. This will apply to all patients, **except those with Medicaid coverage and approved financial assistance**. If a diagnostic service that requires a pharmaceutical agent is needed, a \$100 service fee will be charged to the patient. This fee is to offset the cost of materials.

1. Established patients:
  - a. Appointments must be cancelled at least 24 hours prior to the scheduled appointment time.
  - b. Trinity Medical reserves the right to charge the patient a \$25 fee for a no show or late cancellation of the appointment.
  
2. New patients:
  - a. Appointments must be cancelled at least 24 hours prior to scheduled appointment time.
  - b. In the event of a no-show or late cancellation, Trinity Medical may require a new referral form to be sent from the referring physician.
  - c. Trinity Medical reserves the right to charge the patient a \$25 fee for a no show or late cancellation of the appointment.

I hereby consent to the above and acknowledge that a copy of the No Show/Late Cancellation Appointment Policy Information was made available to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CERTIFICATION: The Undersigned certifies that the Undersigned has read this form, and is either the patient, or has legal authority on behalf of the patient to execute the above and accept its terms; and that all information provided is accurate and complete to the best of the Undersigned's knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Name (please print) \_\_\_\_\_

Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Representative to Patient: \_\_\_\_\_

The Signing of this Form Above, Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_