FAMILY ARTHRITIS CENTER (FAC)

NO SHOW/LATE CANCELLATION POLICY

We reserve your appointment time especially for you. Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We understand that emergencies may arise, and we will take this into consideration for certain circumstances, but repeated cancellations and no shows will result in DISMISSAL from the practice.

I, _____, understand the importance of notifying FAC at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the no show/ late cancellation fee of $75.00 for a follow-up appointment, DEXA, injection or infusion; and $150.00 for a New Patient appointment.

I, _____, give FAC the authorization to charge my credit card $150.00 for the missed New Patient appointment, and $75.00 for each missed appointment thereafter. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed in writing). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees).

I, _____, fully understand and agree to the above.

Credit Card Authorization

Name on card: _____

Patient Name (printed): _____

Card Number: _____

Credit Card Type: _____ Visa _____ Master Card _____ American Express

Expiration Date: _____

Card Identification Number/ CVC#: _____ (3 digits on the back of the card)

I understand and agree that by signing this payment authorization, my credit card will be automatically charged per the agreement listed above and hold FAC harmless for any bank fees incurred due to nonsufficient funds.

Credit Card Account Holder Signature: _____

Date: _____