PARADIGM
HEALTH SYSTEM
A NEW DIRECTION IN HEALTHCARE

Patient Name: _____ **Date:** _____

CANCELLATION POLICY

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We request that you give our office a 24 hour notice in the event that you need to reschedule or cancel your appointment. Our office takes the courtesy to call patients at least one day prior to their appointment as a reminder. If you cancel your visit the day of your scheduled appointment, or fail to show for your appointment without notifying our office, you may be billed.

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be canceled.

By signing this cancellation policy, you are indicating that you understand and agree to the terms explained above.

_____ _____

Patient's signature Date

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