

## MEDICAL APPOINTMENT CANCELLATION/RESCHEDULING POLICY

Thank you for trusting your medical care to Eye Associates of Texas. When you schedule an appointment with Eye Associates of Texas we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/Rescheduling Policy below:

- Effective May 16th, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **\$50.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **\$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Eye Associates of Texas.
- Any new patient who fails to show for their initial visit will be charged a **\$50.00** fee prior to rescheduling.
- The fee is charged to the patient, not the insurance company, and is **due, at latest, by the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls 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 contact our Office Manager, who may be able to waive thiw fee. You may contact Eye Associates of Texas 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

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

\_\_\_\_\_  
Signature (Parent/Legal Guardian)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date