



No-Show, Cancellation, and Late Arrival Policy

At **Greensboro Medical Associates**, we value your time and are committed to providing high-quality care. When you miss an appointment without notice, it prevents us from offering that time slot to another patient who needs it. To help everyone get the care they need, we have established the following policy.

Definitions

- **No-Show:** Failure to attend a scheduled appointment without prior cancellation.
- **Same Day Cancellation:** Cancelling or rescheduling an appointment with less than 24 hours' notice.
- **Late Arrival:** Arriving more than 15 minutes after the scheduled appointment time.

Policy & Procedures

- We require **24 hours' notice** for appointment cancellations or rescheduling.
- **No-Show for three or more appointments** may result in **dismissal from the practice**.

Late Arrivals

- If you arrive **more than 10 minutes late**, it will be at the **provider's discretion** whether to proceed with the appointment.
- If you arrive **15 minutes or more late**, you may be considered a **no-show** and will likely need to **reschedule**.

New Patient

- If a new patient misses their first scheduled appointment without proper notice, they will be assessed a \$100.00 no-show fee. One reschedule will be permitted upon receipt of payment.

No-Show Fees

- **No-Show & Same Day Cancellation:** \$25.00
- **Late Arrival:** Assessed on a case-by-case basis. A late arrival fee will only be applicable if the provider is unable to see you.
- **New Patient No-Show:** \$100.00

Payment of Fees

- **No-show and cancellation fees** are the responsibility of the patient and **are not covered by insurance**.
- All fees must be **paid in full before your next appointment at the time of reschedule**. These fees cannot be set up on a payment arrangement and will be billed to you if they go unpaid.
- Patients with **repeated cancellations or no-shows** may be **discharged from the practice**. In that case, we will provide emergency care for 30 days while you find a new provider.

We Appreciate Your Cooperation as your health and satisfaction are important to us. We value your trust and ask for your understanding as we strive to provide timely care to all patients.

Patient Signature/Patient Representative

Date

Printed Name

Date of Birth