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Cancellation, Rescheduling, and No-Show Policy

As a courtesy, our electronic medical record system will automatically remind you via email the day the appointment is made and 2 weeks before the appointment date. Additionally, an email and text reminder are sent 4 days before and on the day of the appointment.

We understand that situations arise in which you must cancel or reschedule your appointment. However, to ensure our providers maximize their work-time seeing patients, it is our policy that you must notify us at least 48 hours in advance of your appointment date and time if you need to cancel or reschedule your appointment.

If we do not get at least 48 hours' notice of a cancellation or rescheduling of the appt, these time slots are very difficult to fill. They are difficult to fill even with 48 hours notice. This results in providers not being compensated for their time as well as patients otherwise needing to be seen sooner not getting the care they need.

To limit these scheduling and appointment issues, office appointments which are cancelled or rescheduled less than the required 48 hours in advance notice or if you do not show up for the appointment without notice will all be considered a **"NO SHOW"** and you will automatically be subject to a **\$75.00** fee regardless of the reason.

Additionally, having 3 "No-Shows" within a 2-year time frame may be subject to dismissal from the practice.

As a reminder, if you are sick or for any other reason cannot make it to the appointment in time, you can always call us and request an email with a link to be seen online. Please give us at least 10 minutes notice before your appointment to ensure the email with link is sent in time.

THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY AND ARE THE SOLE RESPONSIBILITY OF YOU, THE PATIENT AND MUST BE PAID IN FULL BEFORE THE NEXT APPOINTMENT CAN BE SCHEDULED.

The No show fee may increase to a maximum of \$100 per event in the future if our practice changes this policy. If we make policy changes, it will be started at the beginning of a new year. Please also understand that due to the difficulty in having every patient sign forms again when policy changes occur, that you will not be notified of this change, should it ever occur.

Thank you for trusting us with your care and we hope you understand why we need to have policies like this in place.

Please sign that you have read, understand, and agree with the terms and policies described in this form.

Patient Name (please print)

Date of Birth

Signature of Patient or Patient Representative

Date Signed