

Acute Care Clinic, Inc

Clinic Guidelines

APPOINTMENT SCHEDULING & CONFIRMATION

- **Focused Care:** To remain on schedule, your visit is reserved for the specific reason provided at the time of booking. Addressing additional medical concerns may require a separate appointment.
- **Confirmation Required:** We require confirmation prior to your visit to secure your time slot. Unconfirmed appointments are subject to cancellation.
- **How to Confirm:** You may confirm via our automated text, during our courtesy staff call, or by calling our office directly at **931-484-5379**.
- **Patient Responsibility:** Managing appointment dates and times is the patient's responsibility. The absence of a reminder notification does not waive our attendance policies.

ATTENDANCE & CANCELLATIONS

- **Late Arrivals:** Out of respect for other patients, arrivals more than **15 minutes** late may be asked to reschedule. Being seen within the 15-minute grace period is at the provider's discretion.
- **24-Hour Notice:** We respectfully request at least **24 hours' notice** for any cancellations or rescheduling.
- **No-Show Fees:** Failure to provide 24-hour notice or failure to appear for a visit may result in a **\$25 fee**. This fee is not covered by insurance and must be paid prior to your next appointment.
- **Practice Discharge:** Please be advised that **three (3) or more no-shows** may result in discharge from the practice.

FINANCIAL POLICY

- **Time of Service:** All co-pays, co-insurance, and deductibles are due at the time of visit.
- **Self-Pay:** Patients without insurance are required to pay for their office visit prior to being seen.
- **Additional Services:** Ancillary services—such as urine screening, injections, or X-rays—incur additional charges. Payment for these services is required at checkout.

CONSENT TO TREAT MINORS

- Minors, people under the age of 18, must be accompanied by a parent or legal guardian for all appointments.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have read, understand, and agree to the policies of Acute Care Clinic, Inc. I accept financial responsibility for all co-pays, fees, and services rendered.

Patient Name (Printed): _____

Patient/Guardian Signature: _____ **Date:** _____