PONTE VEDRA
VEIN INSTITUTE

# CANCELLATION / NO SHOW POLICY

At Ponte Vedra Vein Institute, our goal is to provide quality patient care within a timely manner. We have implemented a "No Show and Cancellation Policy" to help better utilize available appointments for our patients. We understand that situations arise in which you must cancel your appointment. However, in those cases, we ask you to contact the office with at least a **48-hour notice**. This will allow the opportunity for another person who's waiting for an appointment to be scheduled in that time slot.

Office appointments that are cancelled with less than **48-hour notice** of the scheduled appointment time may be subject to a **$50.00** cancellation fee.
**Procedure cancellations require at least 48 hours advance notice** and may be subject to a **$100.00** cancellation fee.

Patients who fail to show up for their appointment without contacting the office OR cancel the day of the scheduled appointment will be considered as a "**NO SHOW**". You will be subject to a **$50.00** fee for these visits and **$150.00** fee for procedures.

Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full prior to the patient's next appointment. Each cancellation/no show will be handled by management on a case-by-case basis.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Any questions or concerns regarding our policy can be discussed with management.

As stated above, our goal is to provide quality patient care within a timely manner. Therefore, we ask that you arrive closest to your appointment time as possible. We offer a 15-minute grace period for all patients (with exception to those scheduled after 4 pm). Those who fail to arrive within **15 minutes** of their scheduled appointment time will be asked to reschedule and will be considered a **No Show**.

**Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.**

**Patient Name (Please Print): _____**

**Signature: _____ Date _____**