MARION AND DELAWARE EYE CENTERS
Cancellation, No Show, & Late Arrival Policy For Doctor Appointments

Our Goal:

To provide timely, high quality care to all of our patients. This policy is designed to limit same day cancellations and no shows to enable us to utilize available medical appointments to care for our patients. We understand there are times when you will miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, this prevents other patients from getting scheduled for their needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule and this will delay your evaluation and care.

Description:

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives 15 minutes after the expected arrival time for the scheduled appointment.

Our Policy/Charges:

If it is necessary to cancel or change your scheduled appointment, **we require that you notify by calling one of our offices at least 24 hours in advance.** Appointments are in high demand and your early cancellation will give another patient the opportunity to have access to timely medical care.

- Same Day Appointment Cancellation / No Show: $25.00 – this will not be covered by your insurance company and will be subject to being sent to collections if not paid

- Three (3) documented Same Day Cancellations or No Shows: Patient may be subject to dismissal from the clinic and we may no longer be able to provide you with care

- 15-Minute Late Arrival: We will do our best to work you in to the schedule that same day, but your appointment may need rescheduled to another date

Patient or Responsible Party Name (print name): ________________________________

Signature of Patient or Responsible Party: ____

Responsible Party Relationship to Patient (if applicable): _____________________________

Date: ________________________