No-Show and Late Cancellation Policy Acknowledgment Form

Patient Name (Print): _____ **Date of Birth:** _____

We are committed to providing quality eye care for all our patients. To ensure availability and efficient scheduling, we ask that you read and acknowledge our appointment cancellation and no-show policy below:

Cancellation & No-Show Policy

- **Individual Appointments**: We require at least **24 hours' notice** to cancel or reschedule your appointment.
    - Reasonable exceptions may be considered on a case-by-case basis.
- **Multiple Appointments (e.g., families with 2 or more scheduled visits)**: We require **48 hours' notice** to cancel or reschedule.

    ****Some providers may have a limit of 2 consecutive visits per household****

No-Show and Late Cancellation Fee

- A **$25 fee** will be charged for:
    - Appointments cancelled or rescheduled without sufficient notice (24 or 48 hours as described above).
        - You will be charged $25 for each missed/canceled appointment not per household
    - Appointments missed with zero attempt to contact the office.
- This fee is **not covered by insurance** and must be paid before booking any future appointments.

We understand that unforeseen situations may arise. Please contact our office promptly if you are unable to keep your scheduled time or have missed an appointment.

By signing below, you acknowledge that you have read, understand, and agree to this policy.

Signature of Patient (Parent/Guardian): _____Date**:** _____