Integrative Health and Wellbeing Program
Missed Appointment Policy

Impact of Missed Appointments

The health of all our patients is important to us at the Integrative Health and Wellbeing program. Missed appointments can not only potentially affect your health outcomes, but whenever you miss an appointment without providing adequate notice, another patient misses an opportunity to receive care.

In order for us to provide quality care in a timely manner for all our patients,
A fee of $75.00 will be charged for any missed appointments.
This fee must be paid before your next appointment; this fee is not covered by your insurance.

Definition of Missed Appointment

A missed appointment is any scheduled appointment in which the patient either:

    (1) Does not arrive to their scheduled appointment.

    (2) Cancels their appointment after 12:00 pm on the business day before the appointment, or

    (3) arrives more than 15 minutes late for their appointment and is unable to be accommodated by the practice.

Avoiding Missed Appointments

We understand that situations may arise where you will be unable to keep your appointment. **To cancel or reschedule your appointment, please call us at (646) 697-9355 before 12:00 pm on the business day before the appointment**. (To cancel a *Monday* appointment, please call us by 12:00 pm on *Friday*.) Our business hours are Monday through Friday from 9:00am to 5:00pm, excluding holidays.

We understand that unexpected delays can happen, but we do need to try to keep all our patients' appointments running on time. **Patients who arrive later than 15 minutes after their scheduled appointment time may miss their appointment and incur the missed appointment fee.**

By signing below, I acknowledge that I understand the contents of the Integrative Health and Wellbeing Program Missed Appointment Policy. I agree to be fully responsible for the fee of $75.00 if I miss my appointment and will not submit the bill for these services to my insurance carrier.

_____   _____ _____

Patient Name (Printed)   **Patient Signature**   **Date**