Gynecologic Specialists of Brevard, LLC
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CANCELLATION AND NO SHOW

POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore necessary that if you must cancel your appointment you provide our office with more than a 24 hour notice. This will make an appointment available for a patient who is waiting to be scheduled. With cancellations made less than 24 hours in advance, we are unable to offer these appointments to another patient.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$40.00** cancellation fee. Procedure/ultrasound cancellations require 2 business days advanced notice, without notification they may be subject to a **$40.00** cancellation fee. Urodynamic procedure cancellations require 2 business day advance notice, without notification they may be subject to a **$100.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a **NO SHOW**. Patients who No-Show two (2) or more times within a 12 month period, may be dismissed from the practice thus, they will be denied any future appointments. Patients may also be subject to **a $40.00 fee for office appointment No Show, $40.00 fee for procedure/ultrasound No Show and $100 fee for urodynamic procedure No Show.**

The Cancellation and No Show fees/policy is the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (321-265-5116).

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

______________________________ **Date of birth** __________

Patient Name (Please Print)

______________________________ __________________

Signature of Patient or Patient Representative **Date**

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