Endocrinology Specialists of Colorado, LLC
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We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you do so with appropriate notice. We consider 1 business day (with no less than 24 hours) to be appropriate notice for office appointments, and 5 business days to be appropriate notice for procedure appointments. Such notice enables another person waiting for an appointment to be scheduled in that appointment slot. With cancellations with less than 1 business days' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 1 business days' (with no less than 24 hours') notification may be subject to a **$50.00** cancellation fee. Procedure cancellations require a 5 business day advance notice; without notification they may be subject to a **$150.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered as a **NO SHOW**. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice and may be denied any future appointments. Patients may also be subject to the **$50.00 office appointment No Show fee or the $150.00 procedure No Show fee**.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance and Medicare will not cover these fees.

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 (615/550-4030).

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**