SUMMERVILLE PSYCHIATRIC ASSOCIATES

MISSED APPOINTMENT POLICIES

When you schedule your appointment, you have reserved this time in our schedule, and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office ***at least 24 hours in advance***. To cancel a Monday appointment, cancelation is expected on the prior business day, which is Friday. Appointments may be canceled by contacting our administrative staff or through your patient portal.

We charge a standard $50 fee for no-shows or late cancelations. However, your healthcare provider reserves the right to charge the full session fee. This is necessary because a time commitment is made to you and is held exclusively for you. These charges are not covered by insurance and are the responsibility of the patient or guardian.

Consecutive missed appointments (2 or more no-shows or late cancelations in a row) may result in termination of services.

Unpaid balances on your account are due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay these fees at the time you check in for your next appointment.

Our staff will make every effort to provide patients with reminders for appointments via email, text, or voicemail. However, this is provided as a ***courtesy only***. You are still responsible for remembering your appointment. Not receiving this notice or receiving it after the 24-hour time limit does not excuse you from this responsibility.

We understand that there may be extenuating circumstances that excuse a missed appointment. If you believe that we made an error in scheduling or that your situation merits special consideration for a no-show/late cancelation fee, please submit a written explanation to our office. The written explanation may be sent to **admin@summervillepsychiatric.com.**

Thank you for taking the time to review our missed appointment policies. We hope making them clear will eliminate any misunderstanding if they need to be applied during your treatment.

BY SIGNING BELOW I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Name (Print): _____

Signature: _____ Date: _____

Patient Name (if different from above): _____