

# No-Show Policy

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment so we have the option of offering that appointment to another patient who needs to see the doctor. Please let this letter serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a **\$25.00** charge for office visit cancellation or a **\$50.00** charge for surgery cancellation fee billed to your account that cannot be filed to your insurance.

Thank you for understanding,

Daniel Rivlin, M.D.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

When patient is under age 18 or unable to affix signature:

Patient's name: \_\_\_\_\_

Signature of guardian \_\_\_\_\_

Printed name of guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_