NO SHOW/MISSED APPOINTMENT POLICY

We, at Camp Lowell Cardiology, understand that sometimes you need to cancel or reschedule yourappointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice).You can cancel appointments by calling the following number:(520) 319-5922

To ensure that each patient is given the proper amount of time allotted for their visit and to provide thehighest quality care, it is very important for each scheduled patient to attend their visit on time. As acourtesy, an appointment reminder call to you is made/attemptedtwo (2) business days prior to your scheduledappointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see theprovidersat Camp Lowell Cardiologyand whenever possible, we like to fill cancelled spaces to shorten the waitingperiod for our patients.

2. If less than a 24-hour cancellation is given this will be documented as your first "No Show" appointment.

3. After the first "No-Show/Missed" appointment, you will receive a letter notifying that you have broken our "No-Show" policy. Camp Lowell Cardiology staff will assist you to reschedule thisappointment if needed.

4. If you have 2 "No-Show/Missed" appointments within a one-yeartime period, you will receive awarning letter from our office. This letter will state if you have one more "No Show" we will no longer see you as a patient.

5. If you have 3 "No-Show/Missed" appointments within a one-yeartime, you will receive a letter with your records and a dismissal from thepractice.

I have read and understand Camp Lowell Cardiology's No Show/Missed Appointment Policy and understand myresponsibility to plan appointments accordingly and notify Camp Lowell Cardiology appropriately if I have difficultykeeping my scheduled appointments.

_____   _____   _____

Patient Name   Date of Birth   Date

_____

Patient Signature

_____   _____

Staff Signature   Date