



No Show and Late Cancellation Policy & Consent Form

At **Elite Primary Care**, we are committed to providing quality care to all our patients. In order to do so efficiently and effectively, we require timely notice of any changes to scheduled appointments. This allows us to offer the appointment slot to another patient who may be waiting for care.

Policy:

- Missed appointments (No Shows), late cancellations, or appointment changes with **less than 24 business hours' notice** will result in a **\$50 fee**.
- This fee is **not billable to insurance** and will be the **responsibility of the patient**.
- To avoid the fee, please provide at least 24 business hours' notice when cancelling or rescheduling an appointment.

Example: If your appointment is scheduled for **Monday at 3:15 PM**, you must cancel **before Friday at 3:15 PM**.

- If you call and there is no answer, please **leave a voicemail**. The voicemail system timestamps your message, and this will serve as the official cancellation time.

Acknowledgment & Consent:

I have read, understand, and agree to the above policy of **Elite Primary Care** regarding missed appointments and late cancellations. I acknowledge that I will be responsible for a **\$50 No Show/Late Cancellation Fee** if I fail to provide at least **24 business hours' notice**.

Patient/Guardian Name: _____

Date: _____

Signature: _____