**North Pointe Dermatology- Dr. Corinne G Smith**

**Appointment Cancellation/Late & No-Show Policy**

Recognizing that everyone’s time is valuable and the appointment time is limited, NPD has established a cancellation and no show policy that helps us to provide efficient and effective care to all our patients.

Our office provides courtesy reminder phone calls to all our patients for their appointment. However, it is patient’s responsibility to come to their scheduled appointment in a timely manner or call our office for any changes to their scheduled appointment in a timely manner. Please remember, each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, NPD will charge fee of $ 35.00 to $50.00 for improperly cancelled, missed or late appointments.

**24 business hour Cancellation Notice**: NPD requests its patients to provide a 24 business hour cancellation notice so that we can schedule one of the patients from our waiting list. Any scheduled screen and cosmetic appointment that is not cancelled with a 24 business hour advance notice from the actual time of your appointment, might be charged a late fees of $ 50.00 and all other appointments will be charged a late fee of $ 35.00.

**Same day Cancellations and No show:** A fee of $ 35.00 for follow-up appointments and $ 50.00 for screen and cosmetic appointments will be charged to all patients who do not show up for their scheduled appointment or cancel their appointment on the same day of their appointment.

**Late arrivals:** Patients who arrive late to their scheduled appointment time by 10 or more minutes, might need to be rescheduled. We will do our best to work you in if we possibly can.

Thank you for your support in helping us in providing efficient and effective medical care to all our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

**Name of the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient/ Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**