Triad Pediatrics

Missed Appointment Agreement

Thank you for choosing Triad Pediatrics for your child's health care needs. Caring for your child in an efficient, compassionate manner is of the utmost importance to us. Scheduling around individual's needs and work schedules can be difficult and we do our best to see patients when they need to be seen. A scheduled appointment is a time that we set aside specifically for you. When appointments are missed or cancelled on short notice, that time is permanently lost. We want to honor our valuable patients by minimizing the time they spend waiting for an appointment. If necessary, we request that you call to cancel or reschedule your appointment at least 24 hours before the scheduled appointment time. In order to offset the cost associated with missed appointments, a $25 fee will be charged to your account. In the case of an unexpected emergency, you may call our practice to reschedule without the $25 fee. This may include appointments missed due to illness, adverse weather conditions or other unforeseen emergencies that reasonably prohibit you from canceling an appointment prior to the 24 hours required notice.

As a parent or guardian for a patient receiving services from Triad Pediatrics, I understand and agree with the following:

1. I am responsible for canceling appointments at least 24 hours prior to the appointment. I may cancel an appointment by going to the website or calling the practice.
2. Should I fail to attend or cancel an appointment 24 hours in advance, Triad Pediatrics will notify me of the missed appointment.
3. In order to offset the cost associated with missed appointments, my card on file will be charged $25 for any missed appointment. *Patients are allowed one "free" missed appointment.
4. I understand that Triad Pediatrics may terminate my services due to noncompliance if I have more than three missed appointments in a 12-month period.

I pre-authorize Triad Pediatrics to use the card on file to charge for applicable fees. In the case that there is no card on file, I understand that I will be billed for this fee.

Name _____ Signature_____

Relationship to Patient_____ Date_____

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