RHEUMATOLOGY OF THE WOODLANDS

CANCELLATION / MISSED APPOINTMENT POLICY

Our goal at Rheumatology of the Woodlands is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of other patients, please be courteous and call Rheumatology of the Woodlands promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to have your access to timely care.

HOW TO CANCEL YOUR APPOINTMENT:

To cancel appointments, please call Dr. Johnson's office at 281-297-6476 or Dr. Parke's office at 281-297-7625 at least 24 hours prior to your scheduled appointment. If you do not reach the medical secretary you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will returned you call as soon as possible. Late cancellations will be considered as a "no-show".

NO-SHOW POLICY

A "no-show" is a missed appointment without 24 hours noticed. "No-shows" inconvenience other patients who may need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment without adequate noticed will be recorded in the patient's chart as a "no-show". There will be no charge to the patient for the first event. Any additional "no-shows" will result in a fee of $50.00 charged to the patient and must be paid prior to your next appointment. Any further "no-show" appointments may result in the termination of the patient from the practice.

I have read the above policy completely. I agree to all the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____