Premier Women's Health
Cancellation and No Show Policy

www.mspwh.com

14231 Seaway Road
Suite 3004
Gulfport, MS 39503

Telephone: (228) 206-1905
Fax: (220) 206-1917

Premier Women's Health's goal is to provide excellent medical care to our patients in a timely manner. To better serve the needs of our patients, beginning _____, a Cancellation and No Show Policy will be enforced. This will allow us to better accommodate patients that need to be seen by our providers.
Please read each paragraph below and initial to the left acknowledging your understanding of our office policies.

_____ **Appointments:** We require that you call and give our staff at least 24 hours (1 business day) notice to cancel or reschedule your appointment. If the appointment is not cancelled or rescheduled at least 24 hours (1 business day) in advance you will be charged a $40.00 fee for the missed visit. Arriving 15 minutes late without prior notice to your appointment is considered a late cancellation and is subject to the same $40.00 fee.

_____ **In-office procedure appointments:** We require that you call and give our staff at least 72 hours (3 business days) notice to cancel or reschedule the in-office procedure appointment. If the appointment is not **cancelled or rescheduled** at least 72 hours (3 business days) in advance you will be charged a $150.00 fee.

_____ **Surgeries:** We require that you call and give our staff at least 48 hours (2 business days) notice prior to your **Pre-Operative Appointment** (Pre-op) to cancel or reschedule your scheduled surgery. If the surgery is not cancelled or rescheduled at least 48 hours (2 business days) in advance you will be charged a $200.00 fee.

_____ **Rescheduled appointments/surgeries**: If an appointment/surgery has been rescheduled for two consecutive times, the fee will be applied to the type of rendered service and the third rescheduled appointment will result in pre-payment for rendering services. If you fail to keep the third rescheduled appointment and/or surgery date you could be dismissed from the practice.

All fees must be paid in full prior to scheduling your next appointment and/or surgery. This is nonrefundable and will not be covered by your insurance company.

By signing below, you acknowledge that you have read and understand the policies. I also understand that such terms may be amended periodically by the practice.

_____ _____
Patient Signature **Date**

_____
Print Name (please print)

_____ _____
Relationship to patient if signing on their behalf **Date**