MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for entrusting FYZICAL Therapy & Balance Centers of Pittsfield with your care. When you schedule an appointment with FYZICAL Pittsfield, we reserve that time to provide you with the highest quality of care. If you need to cancel or reschedule an appointment, please contact our office **by phone** as soon as possible and no later than **24 hours prior** to your scheduled appointment. This allows us to offer the time you cannot use to someone else who is waiting for care and can benefit from being seen.

***Please review the Appointment Cancellation/No Show Policy below carefully*:**

• Effective 11/01/2018 any established patient who fails to show up for or cancels/reschedules an appointment without providing at least **24 hours** notice will be considered a 'No Show' and provided **one** courtesy reminder that a subsequent no show or late cancel will result in a $50.00 fee.

• Any established patient who fails to show up for or cancels/reschedules an appointment without providing **24 hours** notice a second time will be charged the $50.00 fee, which must be paid in full prior to the next visit.

• If a third No Show or late cancel/reschedule with less than **24 hours** notice occurs, the patient may become ineligible for future visits with FYZICAL Therapy & Balance Centers of Pittsfield.

• The fee is charged to the patient, not the insurance company, and is due no later than the time of the next office visit.

• As a courtesy, we are happy to provide printouts of scheduled appointments. If you do not receive or retain such a visit summary, you are still responsible for keeping track of your scheduled visits and the above Cancellation/No Show Policy remains in full effect.

FYZICAL Therapy & Balance Centers – Pittsfield: 413-443-4800

Schedule changes must be made by calling the front desk. If it is after regular business hours Monday - Friday, a holiday or weekend, please leave a message. We understand that on rare occasions an unforeseen emergency may occur. If you should experience such an emergency, please contact our Operations Manager to discuss the relevant circumstances.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms. I understand that violations of this policy may adversely impact my ability to be seen.

_____ _____

Printed Name **Relationship to Patient**

_____ _____

Signature (Patient or Legal Guardian) **Date**