No Show Policy

A No Show occurs if a patient does not show for a scheduled appointment within 30 minutes **OR** a parent/guardian has not called to cancel a scheduled appointment at least 4 hours prior to the scheduled appointment. All insured and non-insured patients will be charged a $25.00 No Show fee on the second and third missed appointment and dismissal from the practice may result after any subsequent No Shows within a 1 year time frame. The purpose of this policy is not to punish, but rather to improve scheduling opportunities to allow for adequate use of available patient appointment slots and enhanced use of patient, staff and provider time.

- **No Show #1:** The parent/guardian for the patient will be notified of the missed appointment and advised that subsequent missed appointment, without notifying the practice within the cancellation time frame, will result in a $25.00 fee.
- **No-Show #2:** The parent/guardian of the patient will be notified by phone and receive a letter informing them of the two No Show visits and the $25.00 charge that must be paid prior to being seen for another appointment.
- **No-Show #3:** The parent/guardian of the patient will receive a phone call and letter informing them that their account has been flagged for habitual No Shows and that another no-show may result in dismissal from the practice. They will again be charged a $25.00 fee that must be paid prior to being seen for another appointment.

- Patients who No Show as a Double/Triple/Quad Appointment (2, 3, or 4 patients being seen at the same time) will be charged a No Show fee for each child who misses the appointment and may be restricted from scheduling multiples appointments in the future.
- Patients who No Show as a Double/Triple/Quad Well Child Visit appointments will be charged a $25 No Show fee for each child who misses their appointment and NO future multiple Well Child Visit appointments will be scheduled in the future.

The undersigned has read and agrees to the above No Show Policy of Premier Pediatrics of Houston.

_____	_____
Print Name of Parent	Signature of Parent
_____	_____
Patient Name	Date