MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Gentilly Vision Source. When you schedule an appointment with Gentilly Vision Source, we set aside time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

· Effective May 21, 2018, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No-Show and charged a **$25.00 fee**.

· Any established patient who fails to show or cancels/reschedules an appointment with no 24-hour notice a **second** time will be charged a **$50.00 fee**.

· If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be **dismissed** from Gentilly Vision Source.

· Any new patient who fails to show for their initial visit will not be rescheduled.

· The fee is charged to the patient, not the insurance company, and is **due before we will reschedule the missed appointment**.

· As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to assist with the fees. You may contact Gentilly Vision Source at the numbers below. Should it be after regular business hours Monday through Friday or a weekend, you may leave a message.

Gentilly Vision Source
4114 Marigny St
New Orleans, LA 70122
office: 504-288-2333 ext 0
fax: 504-288-2227
email: info@gentillyvisionsource.com

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____
Signature (Parent/Legal Guardian) Patient Name

_____ _____
Printed Name If not Patient- Relationship to Patient

_____
Date