Carolina Infectious Disease
PA

1774 Metromedical Drive, Fayetteville, NC 28304-3861 Phone: (910) 568-3903 Fax: (910) 568-3908

No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, CID PA sends text message reminders two (2) days in advance of the appointment time. We also call patients the day before for appointment reminders.

As a courtesy, if your schedule changes and you cannot keep your appointment, ***please contact us at least 24 hours before your appointment time*** so that we may reschedule you and accommodate those patients who are waiting for an appointment.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $25.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I agree to provide the above practice and/or its designated payment agent with my debit/credit card information. I understand that my signature and payment information will be maintained on file digitally for future use by this practice. The applicable payment card will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card will be obtained through a card swipe, manual entry, orally in person or over the phone.
☐ Yes ☐ No _____ (Initial)

I understand the "no-show" policy of CID PA and agree to provide a credit card number, which may be charged $25.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided. ☐ Yes ☐ No _____ (Initial)

_____

Printed Name

_____

Patient/Guardian Signature

_____

Date Signed