MEDICAL / SURGICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, your family and all our patients. For helping you effectively and efficiently, we have developed an appointment system that sets aside ample time for a patient.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting the much-needed treatment. To reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy, and it is effective immediately.

OUR POLICY IS AS FOLLOWS:

1. We Request you to give our office **24-hour notice** in the event you need to reschedule your appointment. Our phone number is **425-454-5758**.
2. If you miss an Appointment and do not contact us, we will consider this a missed appointment and a **$50.00** no-show fee will be assessed to you. This applies to late cancellations and "no-shows".
3. If you are late for an appointment, you will be seen according to our schedule for that day and the office visit may need to be shortened in length.
4. Due to the large block of time needed for surgery, last-minute cancellations can cause problems and added expense for the office. If surgery is not cancelled at least **72 hours** in advance you will be charged **$75.00** fee.
5. 1 Hour block times are needed for **URODYNAMICS** procedure, if they are not cancelled at least 72 hours in advance then you will be charged **$75.00** cancellation fee.

This fee will be billed to you directly and it is not covered by the insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in timely fashion and if not, will be subject to collections.

We thank you for trusting us with your medical care.

I have read and understand the MEDICAL APPOINTMENT CANCELLATION POLICY and agree to the terms of this Policy.

Printed Name: _____

SIGNATURE: _____ Date: _____

Dr. Susan Kupferman MD.