WACCAMAW DERMATOLOGY
Skin Cancer Institute

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Waccamaw Dermatology. When you schedule an appointment with Waccamaw Dermatology we set aside enough 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 September 01, 2023, any established patient who fails to show or cancels/reschedules an office appointment or scheduled surgery and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged accordingly:

- $50.00 fee for an office visit no show or late/no cancellation.
- $250 fee for a scheduled surgery no show or late/no cancellation

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

In addition, repeated no show or late cancellations may result in a dismissal from the practice (2 or more no-show/late cancellations within a 12-month period of time)

Any new patient who fails to show may not be rescheduled at the discretion of the practice.

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 may occur, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Practice Administrator, who may be able to waive the No Show fee. You may contact Waccamaw Dermatology 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

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

_____ _____

Signature Parent/Legal Guardian Relationship to Patient

_____ _____

Printed Name Date