Coastal Cardiology,PLLC - Main Clinic
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24 Hour Cancellation & "No Show" Fee Policy for Office & Diagnostic Appointments

Coastal Cardiology PLLC is committed to providing the highest level of quality medical care and personal services to our patients. For every commitment there is an obligation. We feel it's the patient's responsibility to meet their obligation of his or her scheduled appointment.

Coastal Cardiology PLLC has established this policy to help Coastal Cardiology PLLC serve you better. We understand that situations arise in which you must cancel or reschedule your appointment(s). Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Coastal Cardiology PLLC Physician's reserves the right to charge a fee of $25.00 for all missed appointments that are not cancelled within 24 hours advance notice from your scheduled appointment. **Without the proper notification you may be subject to a $25.00 cancellation fee.**

Patients who do not show up for his or her appointment without a call to cancel will be considered a NO SHOW: therefore, a NO SHOW fee will be subject to a fee of $25.00

Cardiology PLLC Physician's reserves the right to charge a fee of $50.00 for all missed appointments in Diagnostics, ("NO SHOWS") and appointments which, absent a compelling reason, are not cancelled with a 24 hour advance notice.

Patients who do not show up for his or her Diagnostic appointment without a call to cancel will be considered a NO SHOW: therefore, a NO SHOW fee will be subject to a fee of $50.00

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in a 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy

______________________________ ______________________________
Signature of Patient Date

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Print Name