Florida Sleep Specialists

DISCOVER HEALTH

No Show/Late Cancellation Policy

We strive to provide excellent medical care to all our patients. To do so effectively and efficiently, we have an appointment cancellation policy that applies to new and existing patients of the practice.

We understand that situations arise in which you must cancel your appointment. It is, therefore, requested that if you must cancel your appointment, give our office at least 24-hour's notice for the appointment and 48- hours' notice for testing. This will allow us to offer that time to another patient on our waitlist.

To remain consistent with our mission, we have instituted the following policy.

- A "No-Show," "No-Call," or missed appointment without proper 24-hour 48-hour notification may be assessed a fee.
  1. **First missed appointment** – You will receive a phone call informing you of your missed appointment with the opportunity to reschedule.
  2. **Second missed appointment** - Any established patient who fails to show or cancels/reschedules an appointment with no 24-48-hour notice will be charged a $50.00 fee.
  3. **Third missed appointment** - If a third, No Show or cancellation/reschedule with no 24–48-hour notice will be charged a $50.00 fee.
  4. **Fourth missed appointment** - You will be notified of your fourth missed appointment and may be subject to dismissal from the practice at the physician's discretion.

- This fee is NOT billable to your medical insurance.
- If you are 15 or more minutes late, the appointment may be canceled and rescheduled.
- As a courtesy, we make reminder calls for appointments one or two days in advance. Please note that if a reminder call or message is not received, the cancellation policy remains in effect.

Follow-up appointment: $50
New Patient Sleep/Weight Consultation: $100
Sleep Study: $250
Sleep Study and MSLT: $500
Home Sleep Test: $100

Financial Responsibility

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and pay in full for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Florida Sleep Specialist/Discover Health for services rendered. I authorize Florida Sleep Specialists/Discover Health representatives to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.
This signature will act as a lifetime authorization for Medicare.

I have read and understood the above Financial Policy and agree to meet all financial obligations.

Patient Name (Please Print)	Patient Signature	Date of Birth	Today's Date
Patient Name (Please Print) (If other than the patient)	Patient Signature	Date of Birth	Today's Date