COLORADO
CONCUSSION
CLINIC

CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Colorado Concussion Clinic. When you schedule an appointment with Colorado Concussion Clinic 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 business 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:

- Patients, who fail to show for their scheduled appointment or did not notify the office within 24 business hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a onetime exception may be granted.
- If cancelled by the practice, then the patient is not subject to this charge.
- If an established patient fails to show or cancels/reschedules three times without the proper notice the patient may be dismissed from Colorado Concussion Clinic.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- 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 occurs and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact Colorado Concussion Clinic 24 hours a day, 7 days a week at 303-932-2030. Should it be after regular business hours Monday through Thursday, 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.

Patient Signature_____ Date: _____