Beachside Pediatrics, LLC

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NO – SHOW POLICY

Dear Parent:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep your appointment. This letter is to notify you that if you fail to give us 24 hour cancellation notice, there will be a $25.00 charge that cannot be filed with your insurance.

Thank – you for understanding.

_____

PATIENT NAME

_____ _____

PARENT/LEGAL GUARDIAN SIGNATURE DATE

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand that the risk associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with me by e-mail. Any questions I may have had were answered.

_____

PATIENT NAME

_____ _____

PARENT/LEGAL GUARDIAN SIGNATURE DATE