OCEAN
INTEGRATED WELLNESS CENTER

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Ocean Integrated Wellness Center. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled 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 January 1, 2023, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Ocean Integrated Wellness Center.
- Any new patient who fails to show for their initial visit will 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**.
- Acupuncture patients are required to leave a card on file at the time of booking their appointment. The credit card on file will be charged immediately for any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office as soon as possible. You may contact Ocean Integrated Wellness Center 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left with at least 24 hours notice are acceptable.

Ocean Integrated Wellness Center (732) 503-4079

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