Alliance Retina

Appointment Cancellation and No-Show Policy

At Alliance Retina, we value your time and strive to provide the best possible to all our patients. To ensure the efficient operation of our clinic and accommodate the needs of all patients, we have implemented a cancelation policy for missed appointments and late cancellations. Please carefully review the following policy:

1) No Show Policy:
   If you fail to show up for your scheduled appointment without any prior notice or cancellation, you will be considered a “no show”. A fee of $25.00 will be charged to your account for the missed appointment.

2) Late Cancellation Policy:
   If you need to cancel or reschedule your appointment, we kindly request that you provide us 48 hours or 2 days in advance notice. This allows us to offer the appointment to another patient in need of care. If you cancel your appointment with less than 48 hours or 2 days in advance notice, a fee of $25.00 will be charged to your account.

3) Surgery or Laser Cancellation Policy:
   If you fail to show up for your scheduled surgery or laser procedure or cancel with less than 48 hours or 2 days in advance notice, a fee of $100.00 will be charged to your account.

4) Payment and Notification:
   Any fees resulting from a no-show appointment or late cancellation will be added to your account and must be paid before scheduling any future appointments. You will be notified of the fee through a phone call, email or through your patient portal. The fee is the responsibility of the patient and not the responsibility of the insurance company.

5) Exceptions:
   We understand that emergencies and unforeseen circumstances may arise making it impossible for you to provide 48 hours or two days in advance notice. In such cases, please notify our office manager as soon as possible to discuss the situation.

6) Multiple Occurrences:
   Multiple no show or late cancellations incidents may result in not only restricting your ability to reschedule, but may require a deposit for future appointments.

We appreciate your understanding and cooperation with this policy. By adhering to this policy, you help us to optimize our schedule, minimize wait times and ensure that all patients receive timely care. If you have any question or concerns, please feel free to contact our office.

I have read and understand the Alliance Retina appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/ Legal Guardian) Relationship to the Patient

_____ _____

Printed Name Date