# PATIENT APPOINTMENT POLICY

**WeCare Family Medicine**, **LLC** our main motive is to provide our patients with the maximum care and excellence in service. We are committed to your well being and providing you health care quality with the most diligence.

As part of being able to provide the best service to our patients, we ask that you cooperate with us by maintaining your scheduled appointments.

**Read and Sign**

_____ **No-Show:** When a patient is scheduled for an appointment and does not call to cancel nor shows up for the appointment.

_____ **Less than 24 hour cancellation :** When a patient is scheduled for an appointment and calls to cancel but does not give the office 24 hours notice.

_____**Cancellation within 24 hours:** When patients call a few hours before any scheduled appointments. We understand that emergencies do happen , but we ask that you help us better serve you by informing the office ahead of time.

In cases of repeated cancellations without prior notice , we reserve the right to discontinue health care and no longer make appointments.

**We reserve the right to charge you a $15.00 fee.**

Thank you for being our patient.

**I have read and fully understand this policy. Please sign and date.**

**Signature:** _____ **Date:** _____