

NO SHOW/MISSED APPOINTMENT POLICY

Our office understands that sometimes you need to cancel or reschedule your appointment and that there are emergencies or your child’s health has improved, in which appointment is no longer needed. If you are unable to keep your appointment, please call us as soon as possible, with at least a 12-hour notice. You can cancel appointments by calling the following number: (916) 771 – 4414 or sending a message via Sutter My Health Online.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. Our office does attempt an outreach call reminder (1) business day prior to your appointment. However, it is the responsibility of the patient/parent to arrive for their appointment on time.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. Therefore, it is very important that you call or message within 12 hours in advance to cancel or reschedule your appointment.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 12 hours’ notice: There is a waiting list to see the Doctor at our office and whenever possible, we like to fill cancelled appointments to allow sooner availability to patients waiting to be seen.
2. If you do not show up to the office for your appointment, this will be documented as a “No-Show” appointment, and you may be charged a \$25 fee.
3. If you have 3 "No-Show/Missed" appointments within a calendar year, you may receive an initial or additional charge to your account of \$25, and dismissal from the practice will be considered.

I have read and understand Dr Mary Ann Ellis-Jammal’s & Dr Heshani Abeysekera’s No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify doctor’s office appropriately if I have difficulty keeping my scheduled appointments.

Patient Name & Date of Birth _____

Patient Signature or Parent/Guardian if minor Relationship to Patient & Date
