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NOTICE OF MISSED APPOINTMENT POLICY

This form shall serve as Notice to our patients of our missed appointment policy, in compliance with their insurance carrier's guidelines.

It must be understood that:

- At least 24 hours' notice is required for canceling or missing an appointment. Failure to meet the 24-hour requirement will constitute a missed appointment.
- Missing two appointments in a row after or including your initial visit can result in patient termination with a provider, or with the clinic, as applicable.
- Missing three appointments over a six-month period may result in termination of care with a provider or with the clinic.
- If a patient utilizes multiple services, such as naturopathic care, acupuncture, massage, behavioral health, laboratory services or any other service provided by the Center for Natural Medicine not specifically listed here, this policy may be applied to individual services and/or individual providers. For example, if a patient regularly attends their naturopathic visits but has missed either two in a row or three acupuncture appointments over a six-month period, that patient may be terminated with the acupuncture provider and potentially from receiving acupuncture in the future.
- Any termination of care will be mailed to the patient in writing at the address on file, and will be documented in their file. Certified proof of receipt of the letter by the patient is not required.
- Patients have the right to appeal termination from the clinic or from individual services to clinic management.
- This signed document will be transmitted to patient's insurance carrier as part of documentation in the event of termination of care.

The patient or Patient's Legal Representative (Guardian) hereby acknowledges that he/she has read and understands this Notice of Missed Appointment Policy. That in the event this Policy is violated, he/she understands and agrees that his/her relationship with the Center for Natural Medicine and its Provider(s) may be terminated.

Patient Name_____ Date_____

Signature of patient / Guardian_____ Date_____

CNM Staff_____ Date_____