Addendum to Patient Information

Notification

I hereby accept to the standards and policy of Orthopaedic & Sports Medicine Center of Miami regarding the No Show and Cancellation fee.

I will be charged the mount of $25.00 for any appointments not cancelled within 24 hours prior to my scheduled time. I also understand appointment cancellations must be called in during the regular business hours Monday thru Friday from 8:30 AM to 5:00 PM.

If scheduled on Monday, my appointment must be cancelled no later than Friday to prevent being charged the cancellation or no show fee.

Example: Appointment on Monday at 9:00 AM must be cancelled no later than Friday at 9:00 AM

Patient Name: ____

Patient / Guarantor Signature: ____

Date: ______________________________

Witness Signature: ____

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