New York BRAIN SPINE & JOINT

**CANCELLATION AND NO SHOW POLICY**

Dear Patient:

We strive to meet and exceed the expectations of all our patients and we are dedicated to rendering excellent medical care to you and the rest of our patients. In order to meet your needs, we are implementing a cancellation and no show policy. This policy enables us to better utilize available appointments for our patients.

Office appointments which are **CANCELLED WITH LESS THAN 24 HOURS** notification will be subject to $25.00 cancellation fee. Cancellation less than 24 hours will be reviewed on a case by case basis.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW**. Patients who no show will be subject to $25.00 for not showing to an appointment.

**NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY AND ARE THE SOLE RESPONSIBILITY OF THE PATIENT AND WILL BE CHARGED WITH THE CREDIT CARD ON FILE PRIOR TO THE NEXT APPOINTMENT.**

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Your health is important to us.

Please sign that you have read and understood this Cancellation and No Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Representative Date Signed

**CREDIT CARD AUTHORIZATION FORM**

Please complete all fields. This authorization will remain in effect until discharge.

| **Credit Card Information** |
|---|
| Card Type: ☐ Mastercard ☐ VISA ☐ Discover ☐ AMEX ☐ Other: |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (mm/yy): |
| Zipcode (from credit card billing address): |

I, _____, authorize New York Brain Spine & Joint DBA Link Medical Services PLLC to charge my credit card above for agreed **CANCELLATION AND NO SHOW POLICY** only. I understand that my information will be saved for future transactions on my account.

_____ _____

Signature of Patient or Representative Date Signed