



# RANCHO PASEO MEDICAL GROUP

## Appointment-Reminder System

Your name: \_\_\_\_\_

I would like to receive reminders about my appointments and other messages related to my treatment via: *(Choose all that apply.)*

Telephone at (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Text Message at (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email at \_\_\_\_\_

## Change, Cancellation, Arrival, & No-Show Policies

*Please read the following and initial to the left of each to signify that you understand:*

I understand that:

\_\_\_\_\_ I must arrive 15 minutes prior to my scheduled appointment for the check-in process, or my appointment will be cancelled;

\_\_\_\_\_ if I do not confirm my appointment, it may be subject to change and/or cancellation;

\_\_\_\_\_ if I cannot make it to my scheduled appointment for any reason, I will provide at least 24 hours notice;

\_\_\_\_\_ if I miss three (3) appointments in a row, I may be dismissed from the clinic;

*(Cancelling or rescheduling an appointment fewer than 24 hours in advance or missing an appointment may result in a no-show and/or cancellation fee of \$25.00 per visit.)*

\_\_\_\_\_ it is my responsibility to update my contact information when it changes.

**I have read and fully understand all of the information above and hereby agree to comply as outlined.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If signed by someone other than the patient, please select your legal relationship to the patient:

Parent    Guardian    Spouse    Representative    Financially Responsible Party