NORTH DALLAS WOMEN'S CARE

SUREKHA MACHUPALLI M.D.

APPOINTMENT CANCELLATION/NO SHOW POLICY

Main Medical Clinic is privileged to provide medical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. This requires planning among individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or canceling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

<u>ESTABLISHED PATIENTS</u> (Patients who have previously seen a physician in our practice)

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance of their appointment will be charged a fee of $25.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday. Patients can leave a voicemail message at the office or with our after hour service if canceling after noon on Friday. If an established patient fails to keep three appointments, or fails to give adequate notice on three occasions, the practice will have the right to dismiss the patient.

FEES

All fees charged by Main Medical Clinic pursuant to this No Show/Cancellation Policy are not payable by your insurance company.
All fees are payable on or before your next office visit to your physician or within 30 days of receipt of a billing statement from our clinic for that fee, whichever is earlier.
Please remember that it is your responsibility to make certain that we have updated, accurate phone numbers so that we may contact you.

Thank you for your consideration and understanding of our policy.

PATIENT SIGNATURE ___________________________
DATE ________________