CPI PHYSICIANS, PC
319 South Manning Boulevard – Suite 116
Albany, New York 12208
Phone (518) 459-1800 / Fax (518) 459-1818

NO SHOW / LATE ARRIVAL / CANCELLATION POLICY

We appreciate the trust that you have placed with our physician(s) and office by choosing us for your healthcare needs. When making an appointment with our physician(s), a set amount of time is reserved for your visits. Please schedule appointments when it is most convenient for you.

Please be aware of our 24-hour cancellation policy. We require at least **24-hours notice** when canceling an appointment. As your physician's office, we expect that you make every effort to adhere to this so that we may provide you and other patients with outstanding healthcare.

Also, please be advised that if you are **more than 15 minutes late** to your scheduled appointment time, we reserve the right to ask you to reschedule your appointment. Being late disrupts patient flow and turns a daily office schedule around.

In accordance to our cancellation policy, please be advised that there will be a **$25.00** charge for each appointment that is not cancelled with 24-hour notification. This fee is **not** covered by your insurance.

Please be advised of our **NO SHOW** policy. Patients that do not show up for scheduled appointments and do not call to notify us that your appointment will be missed, will be charged **$25.00** for each missed appointment. This fee is the patient's responsibility and is **not** covered by your insurance. A total of **3 consecutive NO SHOWS** will result in termination of healthcare services being provided to you at this practice.

I, _____, acknowledge that I have reviewed the **NO SHOW / LATE ARRIVAL / CANCELLATION POLICIES**. I am aware that **24-hours** notice is required for the cancellation of appointments and that I will be asked to reschedule if I am more than 15-minutes late arriving for my appointment. I understand that I am responsible for the $25.00 fee for not adhering to the **NO SHOW / CANCELLATION POLICIES** and that this fee is not covered by my insurance.

Patient's Name: _____

Patient's Signature: _____

Office Staff Witness' Signature: _____

Today's Date: _____