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Cancellation / Missed Appointment Policy

Our mission at River City Rheumatology is always to provide our patients with the best and most timely care possible. To support this goal, we have implemented the following policy regarding appointment cancellations and missed appointments.

Appointment Cancellations:

Out of respect for the medical needs of other patients, please call River City Rheumatology promptly if you are unable to attend your appointment. This allows us to provide care to other patients who are also in need of treatment. If you know you will not be able to attend your appointment, please call our office at least 24 hours previous to your appointment time. Appointments are in high demand, and your early cancellation will support the availability of care to all patients.

How To Cancel Your Appointment:

To cancel an appointment, please call River City Rheumatology's office at 616-320-5330 at least 24 hours prior to your scheduled appointment time. If you cannot reach a member of the front desk staff, please leave a detailed voicemail including your name, date of birth, phone number, and the time of your appointment, and we will call you to reschedule as soon as possible. Appointment cancellations made with less than 24 hours of notice will be considered missed appointments, and may be subject to our No-Show policy, as outlined below.

Missed Appointments:

Missed appointments are also called "No-Shows" and are defined as appointments that have been missed without a 24-hour cancellation notice. This includes appointments missed with no notice, appointments cancelled within 24 hours of the scheduled appointment time, and appointments to which patients arrive 15 minutes late (or later). No-Shows are recorded in the patient's chart, and may result in a fee of \$50.00 for return patient appointments, and \$100.00 for new patient appointments, charged to the patient. A No-Show fee, if applied, must be paid prior to your next appointment.

I have read the above policy completely, and I agree to all of the above outlined terms. I understand that violation of this policy may result in a mandatory fee, if applicable.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

Patient Date of Birth: _____