THE WORLD OF PEDIATRICS

Dr. Lyudmila Vayman
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The World of Pediatrics is experiencing a high number of "NO SHOW" patients. This constitutes an undue burden on the practice and causes serious schedule delays and hardships for other patients. Out of courtesy to your doctor and other patients, please, arrive for your appointments in a timely manner or cancel them 24 hours in advance if you have scheduling conflicts.

NOTICE

ALL PATIENTS WILL BE CHARGED A FEE FOR "NO SHOW" APPOINTMENTS.

As of January 1, 2008 the "NO SHOW" Fee is $50.00.

_____ It is the Patient's, Parent's, or Guardian's responsibility to cancel an appointment at least 24 hours in advance.

_____ You will not be charged a "NO SHOW" fee if we receive a telephone call canceling the appointment prior to the day of your appointment (24 hours) or receive a message via our answering service prior to the day of your appointment.

_____ You will be charged if you cancel via our answering service after 5:00pm on the day prior to your appointment, since this is less than 24 hours before your scheduled appointment. In these circumstances your appointment is no longer considered cancelled, it will be treated as a "NO SHOW" appointment.

_____Failure to pay "NO SHOW" charges may result in discharge from the practice.

_____ If you have a well child appointment (i.e. physical) scheduled and your child becomes ill, then we will change the appointment to a sick visit and reschedule your well child appointment for another date. You still must bring your child into the office for their scheduled appointment time and date.

_____ I understand that multiple "NO SHOW" appointments may result in discharge from the practice.

This agreement is a policy agreement strictly between the patient and Dr. Lyudmila Vayman / The World of Pediatrics.

By signing this agreement you acknowledge notice of our office policy and agree to accept the terms of this policy, regardless of the type of insurance or managed care plan you may have. Further, you are stating that you clearly understand your obligation to cancel appointments 24 hours in advance.

_____ _____
Patient's Name **Patient's Date of Birth**

_____
Parent or Legal Guardian's Name (Printed)

_____ _____
Parent or Legal Guardian's Signature **Date**