SOUTHWESTERN EYE ASSOCIATES

No Show/Cancellation Policy

Financial Responsibility Statement

I, ____________________________ am aware that I will be charged $25.00 for any prior confirmed appointments that I do not show up for, or do not cancel with at least a 24 hour notice.

______________________________ ________________

Patient Signature **Date**

This policy was implemented to assure that our patients keep their appointments or give us sufficient advance notice if they are unable to keep their scheduled appointment time. This is necessary to enable our staff to schedule other patients who are in need of our physician's medical attention, time, and advice. *Please note that if you simply give us a 24 hour minimum notice, you will not be charged. Thank You.