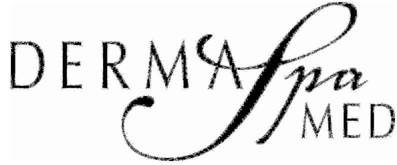

120 North Miller Street, Building C • Santa Maria, CA 93454
Tel: (805) 739-0033 • Fax: (805) 739-1712

Pierre G Labrecque, M.D.

Cancellation and No Show Policies

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In order to do so we have had to implement an appointment /cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments

For a scheduled appointment, please call our office at 805.739.0033 and our staff will try their best to schedule your appointment at the most convenient time possible. As a courtesy, we contact you two (2) business days prior to your appointment to remind you. If we leave you a message, please confirm your appointment by calling our office. If we have not received a confirmation from you for an appointment of 20 minutes or longer, your appointment will be cancelled 24 hours prior to your appointment. You will need to contact the office to reschedule.

Cancellation/Rescheduling of an Appointment

In order to be respectful of the medical needs of the community, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least 24 hours notice, so that your appointment time can be reallocated to someone else. ***Late cancellations will be considered as a "no show".***

No Show Policy

A "no show" is someone who misses an appointment without canceling it at least 24 hours in advance or who fails to keep a scheduled appointment. In the event a 24 hour notice is not given, a fee of $50.00 will be charged for missed office visits and $75.00 for any missed procedures. These fees will be charged to your credit card on file.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY!

I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms. I also understand and agree that I may notify the practice of a change in credit card information at any time.

______________________________	______________________________
Name of Patient	**Relationship to Patient (if minor)**
______________________________	______________________________
Signature of Patient or Responsible Party	**Date**

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Cancellation and No Show Policies

CREDIT CARD INFORMATION

First Name: ___________________________ Last Name: __________________________

Billing Address

Address: ___________________________ Suite, Apartment #: ___________________

City: ___________________________ State: ________________

Zip Code: _____________

Telephone: ___________________

Credit Card Type: ___ Mastercard ___ Visa ___ Discover ___ American Express

Credit Card #: ________________________________

Expiration Date: __________________

Signature of Cardholder: _____________________________________

Date: _______________________

For Office Use Only

Date: _________________

Staff Member: ____________________________

Credit Card Information was received from the patient in ___Office **or** by ___telephone

Cancellation and No Show Policy explained to patient by phone: ___yes