**\*\*\***PLEASE PROVIDE **DRIVERS LICENSE, INSURANCE CARDS AND LIST OF MEDICATIONS\*\*\***

**KHUMALO FOOT AND ANKLE CLINIC, INC**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY CARE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT LEGAL NAME (LAST, FIRST, M.I.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NICKNAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE \_\_ FEMALE \_\_**

**PHYSICAL ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED PATIENT EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFERRED LANGUAGE: \_\_\_ ENGLISH \_\_\_\_ SPANISH \_\_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEED INTERPRETER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYMENT STATUS: \_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_ NOT EMPLOYED \_\_\_\_ RETIRED \_\_\_ ACTIVE MILITARY \_\_\_\_ DISABLED \_\_\_\_\_ STUDENT**

**EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY INFORMATION:**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATION TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**A COPY OF YOUR INSURANCE CARD IS REQUIRED; PLEASE PRESENT BOTH PRIMARY AND SECONDARY (IF APPLICABLE) CARDS TO THE RECEPTIONIST**

**PRIMARY INSURANCE**  **SECONDARY INSURANCE**

**INSURANCE CO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE CO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MALE FEMALE SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE FEMALE SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**KHUMALO FOOT AND ANKLE CLINIC, INC**

**VERBAL COMMUNICATION AUTHORIZATION FORM**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BY LAW, WE CANNOT RELEAE ANY INFORMATION REGARDING YOUR CARE TO ANYONE OTHER THAN YOURSELF WITHOUT YOUR EXPRESS, WRITTEN CONSENT.

PLEASE LIST ANY FAMILY MEMBERS OR OTHER INDIVIDUALS WHO MAY BE INVOLVED IN COORDINATING YOUR CARE, OR PAYMENT FOR CARE. PLEASE INDICATE WHAT TYPES OF IINFORMATION MAY BE SHARED WITH EACH INDIVIDUAL.

|  |  |  |
| --- | --- | --- |
| NAME | RELATIONSHIP TO PATIENT | TYPE OF INFORMATION (CIRCLE) |
|  |  | ALL SCHEDULING MEDICAL BILLING |
|  |  | ALL SCHEDULING MEDICAL BILLING |
|  |  | ALL SCHEDULING MEDICAL BILLING |
|  |  | ALL SCHEDULING MEDICAL BILLING |
|  |  | ALL SCHEDULING MEDICAL BILLING |
|  |  | ALL SCHEDULING MEDICAL BILLING |

\_\_\_\_ **CHECK HERE IF NO ONE IS ALLOWED TO RECEIVE ANY INFORMATION** **ABOUT YOU**

SPECIFIC INSTRUCTIONS OR LIMITATIONS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WE WILL RELY ON THE INFORMATION ON THIS FORM WHEN COMMUNICATING REGARDING YOUR CARE UNLESS YOU REQUEST CHANGES. PLEASE NOTIFY OUR OFFIE IF YOU WISH TO ALTER THE ABOVE DESIGNATIONS.

THIS AUTHORIZATION WILL BE CONSIDERED PERMAMENT UNLESS REVOKED BY YOU. TO REVOKE THIS AUTHORIZATION, PLEASE SEND A SIGNED, WRITTEN REQUEST TO: KHUMALO FOOT AND ANKLE CLINIC 1109 E REELFOOT AVE, STE D UNION CITY TN 38261

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KHUMALO FOOT AND ANKLE CLINIC, INC**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

**\_\_\_\_\_\_(initials)** I authorize Dr. Bhekumuzi Khumalo and personnel of Khumalo Foot And Ankle Clinic, Inc to render medical treatment and evaluations as needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment as necessary.

**CONSENT FOR FINANCIAL RESPONSIBILITY**

**\_\_\_\_\_\_\_ (initials)** My insurance policy is a contract between myself and my insurance carrier. I am ultimately responsible for payment in full for all medical services provided to me. I acknowledge full financial responsibility for services rendered by Khumalo Foot And Ankle Clinic, Inc. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable. In the event of default of payment of charges. I assign benefits to and authorize direct payment to Khumalo Foot And Ankle Clinic, Inc, of which it is entitled. This also includes proceeds and benefits accruing under any settlement structure or otherwise, or awarded in judgement for personal injuries caused by a third party for payment of services rendered by Khumalo Foot And Ankle Clinic, Inc, and/or any of its cellular numbers, which could result in charges to me I may also be contacted by text message or email, using only email addresses I provide.

**PHOTO RELEASE FORM**

**\_\_\_\_\_ (initials**) I hereby authorize Khumalo Foot And Ankle Clinic, Inc, the right to take pictures or videos of me. These picture and/or videos will go to your chart and are mainly used for documentation purposes as well as to show progress of healing. Pictures and/or videos may be used for research purposes or development of educational materials including but not limited to newsletters, flyers, posters, brochures, advertisements, press kits or newsletters. Pictures and/or videos may also be submitted to journalist websites, social networking sites, or any other print and digital communications. There will be no compensation to patient for use of pictures and/or videos. This authorization extends to all languages, media formats and markets now known or hereafter devised. This authorization shall continue indefinitely unless I revoke said authorization in writing.

I understand and agree that these materials will be property of Khumalo Foot And Ankle Clinic, Inc.

I hereby hold harmless and release Khumalo Foot And Ankle Clinic, Inc from all liability, petitions and causes of action which I, my heirs, representative, executors, administrators, or any other person may make on my behalf or behalf of my estate.

I warrant that I am 18 years of age or older and that I am competent to contract in my own name. I have read this release before signing below and I fully understand the contents and meaning of this release.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KHUMALO FOOT AND ANKLE CLINIC, INC**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGE: \_\_\_\_\_\_\_\_\_\_\_ SHOE SIZE: \_\_\_\_\_\_ WIDTH: \_\_\_\_\_\_\_\_**

**HEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL MEDICAL HISTORY** | | | | | | | | |
|  | Y | N |  | Y | N |  | Y | N |
| ALCOHOL ABUSE |  |  | EMPHYSEMA |  |  | LIVER PROBLEMS |  |  |
| ASTHMA |  |  | GASTROINTESTINAL PROBLEMS (specify |  |  |  |  |  |
| BLEEDING/BLOOD DISORDER |  |  | HEPATITIS A B C (CIRCLE) |  |  | MYOCARDIAL INFARCTION |  |  |
| CANCER (TYPE, LOCATION, DATE) |  |  |  |  |  | SEIZURE DISORDER |  |  |
| CONGESTIVE HEART FAILURE |  |  | HIGH BLOOD PRESSURE |  |  | STROKE/MINI STROKE |  |  |
| COPD |  |  | HIGH CHOLESTEROL |  |  | THYROID DISEASE |  |  |
| CORONARY ARTERY DISEASE |  |  | HIV/AIDS |  |  | VASCULAR DISEASE |  |  |
| DIABETES |  |  | IRREGULAR HEART BEAT/A FIB |  |  | OTHER MEDICAL PROBLEMS | | |
| DRUG ABUSE |  |  | KIDNEY FAILURE/INSUFFICIENCY |  |  |

|  |  |
| --- | --- |
| **ALLERGIES \_\_\_\_\_\_\_ NONE** | |
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|  |  |
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| --- | --- |
| **SOCIAL HISTORY** | |
| Have you ever smoked? YES NO | Have you ever used smokeless tobacco? Y N |
| Do you currently smoke? YES NO | Do you crrently use smokeless tobacco? Y N |
| If yes, How many packs per day? \_\_\_\_\_\_\_\_\_\_ |  |

**KHUMALO FOOT AND ANKLE CLINIC, INC**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS, PRESCRIPTION AND OVER THE COUNTER**

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| --- | --- |
| **MEDICATION LIST** | |
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**ARE YOU CURRENTLY TAKING ASPIRIN OR BLOOD THINNERS: \_\_\_\_\_\_YES \_\_\_\_\_\_ NO**

**PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY MEDICAL HISTORY** | | | | | | | |
| Has any family member **(parent, child, sibling or grandparent**) ever had the following? | | | | | | | |
|  | **Y** | **N** | **RELATION** |  | **Y** | **N** | **RELATION** |
| ALCOHOL ABUSE |  |  |  | HIGH BLOOD PRESSURE |  |  |  |
| BLEEDING/BLOOD DISORDER |  |  |  | HIGH CHOLESTEROL |  |  |  |
| DIABETES |  |  |  | KIDNEY DISEASE |  |  |  |
| DRUG ABUSE |  |  |  | OBESITY |  |  |  |
| GI/STOMACH DISEASE |  |  |  | STROKE |  |  |  |
| HEART DISEASE |  |  |  | THYROID DISEASE |  |  |  |
| CANCER (TYPE) |  |  |  | OTHER |  |  |  |

|  |  |
| --- | --- |
| **SURGICAL HISTORY** | |
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**KHUMALO FOOT AND ANKLE CLINIC, INC**

**CANCELLATIONS AND MISSED APPOINTMENTS**

EFFECTIVE 11/1/2024

Our goal is to provide quality individualized medical care. “Late cancellations” and “No Shows” are barriers for individuals who need access to medical care in a timely manner. We recognize that certain life events make it difficult to notify us of the need to cancel or reschedule an appointment. If you must cancel an appointment, please follow the guidelines below.

**CANCELLATION**

To be respectful of the medical needs of other patients please be courteous and notify the clinic when you are unable to show up for a scheduled appointment. We require that you notify the clinic 24 hours in advance. A late cancellation exists when notice to cancel does not occur 24 hours prior to the scheduled appointment time. This timely notification will allow another individual an opportunity to receive treatment. *\*Failure to cancel a scheduled appointment in a timely manner will be recorded in the medical record.*

**HOW TO CANCEL YOUR APPOINTMENT**

There are two ways to cancel your appointment. You may call your specific clinic to speak to a staff member to cancel your appointment and reschedule if needed.

If you have signed up for our web-based patient portal, MyChart, you may electronically cancel an appointment as well as request to reschedule. \*If you have not signed up for MyChart and would like to, please speak to one of our office staff members and they will be happy to help.

**MISSED APPOINTMENTS/NO SHOW**

A “NO SHOW” exists if you fail to appear for a scheduled appointment. \*Failure to appear for a scheduled appointment will be recorded in the medical record.

* Each missed appointment/no show will be followed up by a clinic representative
* Three missed appointments and/or late cancellations may result in a **$25.00 fee** **and/or separation from the clinic**

**I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines, which I do not understand, explained to me.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Signature Date**