



To Our Valued Patients:

**Cancellation Policy**

Providing complete and thorough medical care to our patients is our number one goal. Our providers and staff members work very hard to maintain this goal and we ask that patients make every effort to adhere to the appointment time that has been reserved for you. We kindly ask that you give us **24** hours notice in the event that you are unable to keep your appointment in order for us to schedule and care for other dermatology patients.

Appointments either missed or cancelled without a **24** hour notice will be charged a **\$50.00** fee. This fee will automatically be charged to your account. You will be personally responsible for this charge and it will not be billed to your insurance company. There is a **\$100.00** cancellation fee for surgeries that are cancelled less than **3** business days from the scheduled day and time of surgery unless the cancellation is due to insurance denial or medical necessity.

**Prescription Refill Policy**

Providing patients with the highest standard of care requires that patients also take part in the process of monitoring their conditions. It is imperative that patients return for follow up visits in order to monitor certain skin conditions and also to allow us to closely watch areas that are of concern. In the event that you have received a prescription medication from our office, please make sure to ask either the provider or the medical assistant when you will need to return for your follow up visit in order to refill your prescription medication.

Patients taking oral medication on a daily basis need to be seen no less frequently than every six (6) months. We do not refill oral medications over the phone. Patients using topical medications only need to be seen no less frequently than once a year. We will not refill any prescriptions issued by another provider without an evaluation by one of our providers. Please make sure to schedule a follow up visit prior to leaving the office to prevent your prescription medication from running out.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

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