**NO SHOW/MISSED APPOINTMENT POLICY**

Our goal at Active Solutions Therapy Services is to give every patient the very best care! We understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: **505-286-7838**

**To ensure that each patient is given the proper amount of time allotted for his/her treatment and to provide the highest quality care, it is very important for each scheduled patient to attend his/her visit on time.**

**Therapy is very similar to taking an antibiotic; it only works if the medication is taken on a regular basis. Please help us to help you with your treatment by attending all of your scheduled appointments.** As a courtesy, an appointment reminder is attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for the appointment on time.

**PLEASE REVIEW THE FOLLOWING POLICY:**

1. Please cancel your appointment with at least a 24 hours notice: This will allow us to notify patients that are on the wait list and fill cancelled appointments.
2. If less than a 24-hour cancellation is given, this will be documented as a “No-Show” appointment.
3. If you are not present to the office for your appointment, this will be documented as a “No-Show” appointment.
4. After the first “No-Show/Missed” appointment, we will attempt to notify you of your missed appointment. We will gladly assist you to reschedule this appointment if needed.
5. After the second “No-Show/Missed” appointment within a six month time period, and violation of the No Show Policy we will have to assess a $25.00 no show fee. This fee must be paid before your next treatment.

**I have read and understand Active Solutions No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Active Solutions appropriately, if I have difficulty keeping my scheduled appointments.**

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Patient Name Date of Birth Date

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Patient Signature or Parent/Guardian if minor Relationship to Patient

\*\*\* Active Solutions Therapy Services reserves the right to make changes to this policy as needed.