**No-Show and Late Cancellation Policy**

At The Woodlands Allergy, Asthma & Immunology Center, we understand that occasionally circumstances may arise that prevent you from keeping your scheduled appointment. We are committed to providing exceptional care to all our patients, and to do so effectively, we must ensure that appointments are managed efficiently. Please review our policy in detail.

1. 48-Hour Notice: We kindly request that you provide **at least 48 hours' notice** if you need to cancel or reschedule your appointment. This can be done by phone (281-713-9011) or email (frontdesk@woodlandsallergy.com).

2. Cancellation Fees: If you cancel in less than 48 hours or fail to show up for your scheduled appointment, the following fees will apply:

- **$100** per missed visit appointment.

- **$200** per missed procedure appointment (examples: skin test, patch test, oral challenge).

3. Credit Card on File: To become a patient at our clinic, we require a valid credit card to be kept on file. This card **will be charged** the applicable fees in the event of a late cancellation or no-show AND any unpaid balance.

4. Fee Payment: Any outstanding no-show or late cancellation fees OR any remaining balance **must be paid** before booking your next appointment.

5. Repeated No-Shows: To maintain the quality of care for all our patients, we have a strict policy regarding repeated no-shows. If you miss **two appointments** without proper notice, we regret that we will no longer be able to schedule future appointments at our clinic.

**Acknowledgement of** **No-Show and Late Cancellation Policy**: **I have read, understood, and agreed to the rules and regulations detailed within this document. I understand that I may be charged fees for no-show or late cancellations. I authorize my credit card on file to be utilized for above.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*