ARIZONA ALLERGY ASSOCIATES

Practice Limited to Allergy, Asthma, and Immunology
Adult and Pediatric

Cancellation/No Show Policy

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In order to ensure that quality patient care is maintained and all patients can be accommodated, it is important that you notify Arizona Allergy Associates office of your intentions to cancel or change your appointment at least **twenty-four business hours (24)** prior to your scheduled appointment by calling (480) 897-6992. If you have an appointment scheduled on Monday, please call the office on the preceding Friday (one business day) to cancel or change that appointment. In an emergency you may leave a message over the weekend. Please do not use our web site to send messages to the practice as they are not reviewed daily.

If no call is received within this time period you will be considered a "No Show" and a charge will be assessed at $75.00.

Please take the time and consideration needed to provide the proper notification of your intent to cancel your visit with your Provider.

We understand there may be times you will miss an appointment due to family emergency or obligations and we will take these situations into account, however, we strongly encourage you to inform us within 1 business day prior to your scheduled appointment so that we can accommodate another patient in that visit slot.

I, _____ have read and had the above policy explained to me. I agree to abide by the request to notify the practice at least one business day in advance of a scheduled appointment of my intention to cancel or change my appointment. I understand this assessment will not be charged to my insurance carrier and I will responsible for paying it.

I also understand that with three (3) or more missed appointments, Arizona Allergy Associates has the right to discharge me from the practice. If discharged, Arizona Allergy Associates will notify me in writing via certified mail.

I have read the above information, and I agree to these terms:

_____ _____
Signature of Patient or Responsible Party | Date

_____ _____
Printed Name | Date of Birth

_____
Relationship to Patient

_____ _____
AAA Witness Signature | AAA Witness Printed Name

Updated: 3/27/2009